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CARDIAC ARREST

STUDY OF A THIRTY-YEAR PERIOD OF OPERATING ROOM DEATHS AT MASSACHUSETTS GENERAL HOSPITAL, 1925-1954

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• *Cardiac arrest is the sudden cessation of demonstrable cardiac activity unexplained by gross hemorrhage, shock, or asphyxia. In the decade 1945-1954 it was taken as the probable cause of 50 out of a total of 84 operating room deaths that occurred during 103,777 surgical procedures.*

In this decade the proportion of older patients was higher than in the preceding two decades, and the highest percentage of cases of cardiac arrest occurred in the 70-79 year age group. The incidence was 30 times as high in patients in admittedly poor physical condition as in patients in good condition; it was also higher in patients with heart disease. Additional contributing factors were the deepening of anesthesia, hypoxia, reflex phenomena, and improper choice or management of anesthesia.

Emergency thoracotomy and manual systole were carried out in 58 cases of cardiac arrest, with 26 recoveries. During the last 10 years the recovery rate in cardiac arrest was 37%, and during the last 5 years it was 50%.

In recent years there has been an apparent increase in the incidence of cardiac arrest. The purpose of this study is to determine as accurately as possible, after the fact, whether this increase is absolute or only relative and to find as many of the common causative factors related to cardiac arrest as we can. The data for this study were collected by analyzing and classifying the clinical records of all patients who died in the operating room and of all patients who have been given diagnoses of cardiac arrest during the 30-year interval from 1925 to 1954. For the first 20 years of this period only those surgical services having complete statistical records were included in this study. In the last 10 years all cases are fully documented. Neurosurgical cases, however, have not been included because of the relationship of the operative procedures experienced to the vital centers. Arrests during cardiac surgery also have been excluded unless they led to death. In this event they are included in the tabulation of total operating room deaths. This study covers 189,815 anesthetic and surgical procedures.

Incidence of Operating Room Deaths and Cardiac Arrests

The relative incidence of cardiac arrests and operating room deaths is roughly parallel until the last five years, when more cardiac arrests occur than operating room deaths. This reflects the successful treatment of this emergency to the point where, during the last five years, 50% of these patients have completely recovered. The total incidence of operating room deaths for the 30-year period is 1:1,091; of cardiac arrests (including cases of recovery or delayed death), 1:1,406.

Categories of Operating Room Deaths

All operating room deaths for this 30-year period have been examined and classified as to the most probable cause of death (table 1). Broad categories, which are defined below, have been chosen. In some instances, when more than one factor was present, cases have been listed in the category that seemed most appropriate. Often the choice of the proper category has been difficult. Classification was particularly troublesome in those cases in which there were lesser degrees of hypoxia. This really amounts to classifying the cases of operating room deaths as to what seemed to be the most probable cause.

All cases in which there was a sudden cessation of demonstrable cardiac activity are included in the category "cardiac arrest," except where gross hemorrhage, shock, or asphyxia appeared to be the immediate cause of death. The apparent abruptness of onset and temporary response to treatment in some instances led to listing in this category. A variety of causes was responsible for placing patients in the hypoxia category, such as

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vomiting with aspiration; infections with edema of the pharynx, floor of the mouth, and neck; obstructing secretions; massive pulmonary collapse; flooding of the respiratory passages with blood or pus; and convulsions with impaired respiration. All cases of uncontrollable bleeding that resulted in death in the operating room were included under "hemorrhage." Under "shock" were included prolonged and extensive operative procedures with gradual deterioration of the patient's condition. These cases were characterized by a rising pulse rate, falling blood pressure, cyanosis, and a cold skin. Included under "moribund" were all extremely critical cases in which operation was a last resort, with the gradual death of the patient during the operation. Examples of conditions that led to placing patients in this group are massive pulmonary embolism, extensive peritonitis, overwhelming sepsis, and severe trauma.

TABLE 1.—*Classification of Operating Room Deaths*

Probable Cause	1925-1934	1935-1944	1945-1954
Cardiac arrest	25	10	50
Hypoxia	10	14	9
Hemorrhage	5	4	14
Shock	..	2	5
Moribund	12	8	6
Total	52	38	84
No. of procedures	27,040	44,098	103,777
Incidence of operating room deaths	1:730	1:1,266	1:1,235
Incidence of fatal cardiac arrests	1:1,518	1:4,810	1:1,647*

* Includes 13 cardiac arrests in which patient died later.

Comparison of the Categories of Operating Room Deaths over Three Decades

From 1925 to 1944 all patients were studied who died in the operating room. They are included in this study. Doubtless, in the early years, there were unrecorded instances of patients undergoing surgery who had sudden absence of vital signs with subsequent recovery. With the present interest in such occurrences, a much fuller record is now invariably made of such cases than was true in the beginning. A review of the case records of the first 20 years shows that in at least 35 of these cases diagnosis of and treatment for cardiac arrest would have been given under our present program of resuscitation. In 10 cases, manipulation of the heart from below the diaphragm is described. This (if it can be taken as representative) indicates an incidence of cardiac arrest of 1:2,458 from 1925 to 1944.

From 1945 to 1954, 50 cases were classified under cardiac arrest terminating with death in the operating room. There were an additional 13 cases in which cardiac action was temporarily restored for periods of from four hours to three weeks. Thirty-seven patients survived, giving a total of an even 100 cases of cardiac arrest in this last 10-year period. This gives a fatal incidence of 1:1,647 and a total incidence of 1:1,038. This is about two and one-half times the total incidence of the previous 20 years but only about one and one-half times the fatal incidence because of the patients who are now being saved. The total incidence of arrest by decade is 1:1,518 for 1925-1934, 1:4,810 for 1935-1944, and 1:1,038 for 1945-1954. The data show that cardiac arrest is the major single cause of operating room deaths and that there has been an absolute increase in the incidence of cardiac arrest in recent years.

Table 1 also shows the variation in the other causes of operating room deaths. The incidence of hypoxial deaths in the last decade has decreased to one-third of what it was in the previous decade. The number of patients in each decade must be considered to appreciate the full change taking place over the 30 years. There has been a steady decrease in the number of preoperatively moribund patients dying in the operating room; however, during the past two decades, the total incidence of operating room deaths has not changed appreciably.

Factors Predisposing to Cardiac Arrest

Further examination of the cardiac arrest case records discloses certain factors that are at least partially responsible for the increase in incidence of this catastrophe. Detailed study has been limited to the cases of the past 10 years because many of the clinical histories prior to 1945 were too incomplete for this purpose. Where possible, however, comparisons with the previous two decades were made.

Age.—The age distribution by decade of all surgical patients and of those with cardiac arrest is shown in table 2. Also shown is the relative incidence of cardiac arrest for each decade of age. There is a steady increase in cardiac arrests beyond the second decade of age. There has been an increase in the number of elderly people undergoing surgery. The greatest increase was in those over 70. In 1941 these comprised 5.5% of all surgical patients, while in 1954 they were 12.7%. In 1941, 30.2% of all surgical patients were over 50. In 1954, 47.9% were 50 or over. There was in this period a 55% increase for those over 50, a 93% increase for those over 60, and a 130% increase for those over 70. Table 2 compares the three decades studied as to the age of patients suffering cardiac arrests. The percentage of cardiac arrest patients 50 years of age or older in the total group has risen from 48 in the first decade to 78 in the third. The average age of these patients has risen from 42 to 61 over the same period.

TABLE 2.—*Age of Patients with Cardiac Arrest*

	Cardiac Arrest Patients						All Surgical Patients,*
	1925-1934		1935-1944		1945-1954		1945-1954,
Decade	No.	%	No.	%	No.	%	%
0-9	1	12	1	10	3	3	5.6
10-19	1	12	1	10	..	..	7.4
20-29	..	..	..	..	3	3	12.6
30-39	1	16	..	..	5	5	15.4
40-49	3	12	2	20	11	11	17.2
50-59	3	32	1	10	16	16	17.1
60-69	1	16	3	30	24	24	15.0
70-79	..	..	1	10	29	29	8.2
80+	..	..	1	10	9	9	1.9
No data	..	..	..	..	..	..	0.2
Av. age	42		50		61		45

* 103,777.

Physical Status.—The cases have been classified according to their preoperative physical status according to the system of the American Society of Anesthesiologists (table 3). A comparison of the physical status distribution of all surgical patients from 1945 to 1949

with the physical status of cardiac arrest patients (1945 to 1954) is also shown. From 103,777 cases in the most recent decade with the best-documented cases, the incidence of cardiac arrest was 1:3,296 for those in good physical status (groups 1, 2, and 5) and 1:102 for those in poor physical status (groups 3, 4, 6, and 7), a thirty-fold difference.

TABLE 3.—*Physical Status of Patients with Cardiac Arrest*

Physical Status *	Cardiac Arrest Patients			All Surgical Patients,† %
	1925-1934	1935-1944	1945-1954	1945-1949
1 Good	4	2	4	59.2
2 Fair	2	3	24	29.7
3 Poor	7	3	37	5.2
4 Serious	..	..	7	0.6
5 Emergency, good	4	..	1	3.2
6 Emergency, poor	5	1	17	1.0
7 Moribund	3	1	10	0.2
No data	..	..	..	0.9
1, 2, 5—Good	10-40%	5-50%	29-29%	92.1%
3, 4, 6, 7—Poor	15-60%	5-50%	71-71%	7.0%

* American Society of Anesthesiologists classification.
† Analysis of 53,556 surgical procedures.

Heart Disease.—The preexisting cardiac status of the group with heart disease was carefully evaluated. Heart disease was present in 60 cases; in many of them it was severe. From all of the 15,314 general surgical ward patients operated on during the years 1946 to 1948, 12% were found to have significant preoperative cardiovascular disorders. While we do not have comparable data on the private patients, it is not likely that they would be much different. The incidence of heart disease in the arrest group is five times the incidence in the surgical population studied. In 23 of these 60 patients, combinations of more than one type of heart disease were present in the same individual. Of the 11 with rheumatic heart disease, 6 had coronary artery disease in addition. Two of the three patients with syphilitic heart disease had aortic regurgitation and congestive failure; the other syphilitic patient had an aortic aneurysm. Ten of the 29 patients with hypertensive heart disease had no other evidence of heart disease, while 19 had concomitant coronary artery disease.

Coronary artery disease, as demonstrated by a history of angina, previous myocardial infarction, or significant electrocardiographic indications, was present in 41 patients. Of these 41 patients, 17 were asymptomatic, 7 had angina on effort, and 3 had angina at rest. Ten had experienced known previous myocardial infarction, and in four patients without clinical evidence of coronary disease unexpected myocardial infarcts were found at autopsy. Acute coronary thrombosis or myocardial infarction was demonstrated at autopsy in nine cases and was presumably directly related to the arrest. Congestive failure was present in 20 of these 60 patients. At the time of operation, this was mild in 15, moderate in 4, and severe in one. Digitalis had been administered to 39 of this group of 60, and 17 had been given quinidine.

Anesthesia and Anesthetists.—The type of anesthesia employed is indicated in table 4. The incidence of arrests under each type of anesthesia is shown and compared with the average percentage of the various types of anesthetics administered in this hospital.[2] Ether was the primary anesthetic in 72% of the arrest cases, while it was represented by only 48% of the total anesthetics given. However, no definite conclusions can be drawn regarding the toxicity of the anesthetic agents because of the contributory pathology in many of the patients with arrest and the fact that at this hospital ether has been predominately the anesthetic of choice in the poor risk patient. Further consideration of the effects of the anesthetic will be presented later in the discussion of the causes of cardiac arrest. The relative experience of the anesthetists in the cases of arrest has been evaluated. Fifty-five per cent of anesthesias associated with cardiac arrest were given by the more experienced members of the department. This is to be expected, since they, as a rule, anesthetize the patients with complications or those who are poor risks.

Causes of Cardiac Arrest

With the many factors involved, it is impossible to determine the exact cause of cardiac arrest in many instances. A given factor was found in some cases to be clearly the cause of the cardiac arrest; in other cases, the same factor was responsible for an operating room death without cardiac arrest as, for example, hypoxia. Preexisting disease such as heart disease, sepsis, and anemia often seemed to contribute to the arrest. In other cases, errors in choice and management of the anesthesia were responsible. Study of the cases indicated that there were several common associated factors and causes; these are listed in table 5.

Arrest occurred during increasing depth of anesthesia in 34 instances. This was associated with induction in 9 cases, with endotracheal intubation in 13 cases, with intra-abdominal exploration in 11 cases, and with deep anesthesia during thoracotomy in one case. With prompt thoracotomy and manual systole, elimination of the anesthetic and ventilation with oxygen, 24 of these 34 patients recovered completely. In two instances temporary heart action was restored. The eight other patients died in the operating room.

TABLE 4.—*Type of Anesthesia in Patients with Cardiac Arrest*

Anesthetic	Total Surgical Anesthetics, %	Cardiac Arrest, %
Ether and nitrous oxide and/or thiopental sodium	48	70
and muscle relaxant	.. *	2
Thiopental sodium and nitrous oxide	18	1
Thiopental sodium and muscle relaxant	1	2
Cyclopropane	2	4
Ethylene or nitrous oxide	1	4
Spinal	5	8
Local or regional	22	6
Topical	..	2
None	..	1

* Less than 1% for the period studied.

Various types of reflex phenomena appeared to be associated with six arrests. The nature and circumstances of these reflex phenomena are inadvertent tracheal stimulation during thyroidectomy, pulmonary hilar exploration, endotracheal intubation, urinary bladder inflation, manipulation of a fractured hip under light anesthesia, and turning from back to side immediately after

pneumonectomy. In the last four instances mentioned there was a second arrest or marked vagal cardiac inhibition when the same stimulus was repeated. All these patients recovered completely.

Hypoxia was the principal factor in 13 cases; only 4 patients recovered. In three cases, temporary restoration of cardiac function was accomplished. The remaining six patients died in the operating room. Of the nine

TABLE 5.—*Factors Associated with Cardiac Arrest (100 Cases)*

Factor	No. Cases	Recovered	Temporary Restoration	Died
Increasing depth of anesthesia	34	24	2	8
Reflex phenomena	6	6	0	0
Hypoxia	13	4	3	6
Moribund	9	0	1	8
Cardiovascular collapse	9	0	5	4
Heart disease	16 *	3	0	13
Unexplained	13	0	2	11

* In 11 cases listed under other factors, heart disease was also present.

patients who were moribund preoperatively and had an arrest, heart action was restored in only one temporarily; all others died in the operating room. In nine cases the arrest appeared to be precipitated by acute cardiovascular collapse. Poorly chosen or administered spinal anesthesia, previous hemorrhage, severe anemia, extensive colonic obstruction, or shock from long operative procedures contributed to this category. In five instances spinal anesthesia produced cardiovascular collapse precipitating arrest. Twice, spinal anesthesia was administered to patients with severe intestinal obstruction and was followed promptly by cessation of cardiac function. Once, spinal anesthesia was given to a patient with chronic hemorrhage, anemia, and probable low blood volume. In two cases spinal anesthesia was poorly managed in elderly patients with fractured hips. In three of these five cases, cardiac action was restored for a period by thoracotomy and supportive treatment. In two patients, the arrests occurred with the induction of general anesthesia after severe hemorrhage. In the remaining two patients, long operative procedures were associated with the development of operative shock and sudden arrest. There were no complete recoveries in the acute cardiac collapse group, although cardiac function was restored temporarily in five of these nine patients.

Demonstrable heart disease was present in 60 of the 100 cardiac arrest cases. It seemed to be the most likely causative factor in 16 cases, and in 44 cases listed under other causes it was also present and of unknown importance. Of the 16 patients in this category, 3 recovered from their cardiac arrests, but 2 of these 3 died of heart disease during the same hospital admission. In 13 cases no cause could be determined. Heart action in 2 of these patients was temporarily restored; the other 11 patients died in the operating room. Postmortem examination was done in 5 of these 13 cases and failed to account for the arrest.

Results of Treatment of Cardiac Arrest

Table 6 shows the type of treatment instituted in the cases of arrest and the results obtained. It also shows the type of arrest, when observed. Emergency thoracotomy and manual systole were carried out in 58 cases. In four instances, the chest was already open and treatment started at once. Two of these patients recovered completely, and, in the other two, cardiac function was restored for a few hours. Study of the time elapsing between recognition of arrest and beginning of manual systole shows that neurological complications are infrequent in survivors, if thoracotomy is performed within four minutes or less. Neurological sequelae were observed in all patients who had restoration of cardiac action when thoracotomy was delayed longer than four minutes. In the 45 cases where thoracotomy was instituted within four minutes or less, 26 recovered and only one had some demonstrable central nervous system involvement. In seven cases 5 to 13 minutes elapsed, and only one in this group survived. Eight minutes passed before thoracotomy was carried out in this case, and this patient had transient central nervous system changes, which disappeared after 48 hours. In six cases no time interval is recorded, and all the patients died.

In 42 arrests the chest was not opened. There were several reasons for this. In 11 cases there was spontaneous recovery without thoracotomy or before it was accomplished. Five patients had such extensive heart disease that manual systole did not seem justified. Five patients were moribund, and again such measures did not seem appropriate. In the other 21 cases the advisability and advantages of thoracotomy and manual systole were not recognized. Most of these cases occurred in the first five years of this period (the last decade). At present, almost all patients having sudden cessation of cardiac function have immediate thoracotomy and manual systole.

The heart was found in asystole in 51 cases. Ventricular fibrillation did occur in four of these patients during the resuscitative period; none of them survived. The recovery rate in those with asystole was almost 50%. In 11 instances cardiac action was restored for a period of hours to as long as three weeks. Most of these 11 patients exhibited signs of cerebral changes, usually attributed to hypoxia. Ventricular fibrillation was observed in five patients on opening the chest. In four cases

TABLE 6.—*Surgical Treatment and Type of Cardiac Arrest*

Treatment	No. Cases	Recovery	Death	
			In O.R.*	Delayed
Thoracotomy and manual systole	58	36	21	11
Subdiaphragmatic massage	12	3	7	2
Incision in chest wall only	1	1	..	..
Pounding on chest wall	1	1	..	..
No surgical interference	28	6	22	..
Type of Arrest (determined at thoracotomy)				
Asystole	51	23	17	11
Fibrillation	5	1	4	..
Weak beat	7	7	..	..
Not determined	42	11	29	2

* Operating room.

this condition was treated with defibrillatory electric shock of proper intensity, and one survived. Of these five patients, three were receiving cyclopropane, one was receiving ether, and the one who survived was receiving thiopental sodium and nitrous oxide.

A very weak contraction of the myocardium was observed at thoracotomy in two patients. In both instances

ether was being used. With elimination of the anesthetic, forceful heart action returned. Manual systole was not necessary, and both patients survived. Thoracotomy was not performed in 42 cases, and there is no conclusive evidence as to the cardiac state during the period of arrest.

Comment

This study of 189,815 patients undergoing anesthetic and operative procedures during the past 30 years in this hospital shows that there was a steady decrease in the incidence of cardiac arrest for the first 20 years of the period, followed by a marked increase in the last decade, particularly in the past five years. The decrease in incidence of cardiac arrest from 1925 to 1944 appears to be due to improved preoperative preparation of surgical patients and improved selection and administration of anesthesia. As the years passed, the treatment recorded in the case histories shows a steady improvement in the care given these patients. The dangers of spinal anesthesia in the critically ill patient were recognized. The training and experience of the surgical and anesthesia staff had improved. Much had been learned regarding adjuvant therapy, such as that afforded by blood transfusion and other intravenously administered fluids.

With the continuing advances in the care of surgical patients, one would expect a further decrease in the incidence of cardiac arrest. The reverse of this has been found. As the very result of these advances in medical care, old and poor risk patients have come to surgery who in earlier years would have been considered unsuitable operative risks. This is noticeable in the case of patients with cardiovascular disorders such as hypertension and coronary artery disease. Newer types of surgical procedures have been devised for the treatment of diseases common in the aged, such as the degenerative and neoplastic diseases. An increasing proportion of surgical patients is in the older age groups. It is in this group that the greatest number of cardiac arrests have occurred. In the period studied there is an increase in the incidence of cardiac arrest for each decade of age beyond the second. From age 20 to 30 there was one cardiac arrest for every 4,358 procedures, while in patients 80 or over the ratio was one cardiac arrest for every 219 procedures. It is our conclusion that increased age predisposes to this twentyfold increase in cardiac arrest.

Poor preoperative physical status predisposes to cardiac arrest. The incidence was 30 times as great among patients classified as in poor physical status as among those classified as in good. Heart disease was present in 60% of the cases of cardiac arrest. This is five times the incidence in the general surgical population. Apparently heart disease predisposes to cardiac arrest. The responsibility of the anesthetic agent or technique in the production of cardiac arrest is difficult to evaluate properly because of the serious underlying pathology in many instances and external factors governing the choice of anesthesia. Massive pulmonary emboli apparently caused two arrests, and these would probably have occurred with any anesthetic agent. Because of such factors, it does not seem right at present to theorize as to the incidence of cardiac arrest with any particular agent.

One circumstance has been increasingly apparent in the arrest data. This is the fall in blood pressure, slowing of the pulse rate, and eventual cessation of cardiac action observed with increased depth of general anesthesia. This has been observed more frequently with ether, but similar effects have been seen with cyclopropane and with thiopental sodium, although none of the arrests in this series have been attributed to deep cyclopropane or thiopental anesthesia. This depressant effect has been seen more frequently in elderly patients and in those with heart disease than in young and healthy individuals. This appears to be due to the depressant effect of the anesthetic agent upon the myocardium. Concentrations of the anesthetic agent that are safe for the healthy heart appear to depress seriously the diseased heart. If this condition is promptly recognized and treated, normal function returns in a large proportion of the cases. In some instances artificial respiration with oxygen and elimination of the anesthetic agent sufficed to restore circulation in cases of apparent arrest. More frequently manual systole was required.

In 34 instances the arrest was associated with increasing depth of anesthesia. Twenty-four of these 34 patients, or 71%, recovered completely. This is a higher percentage of recovery than is associated with any other predisposing cause except reflex phenomena, in which the recovery rate was 100% for a small number of cases, six. The proportion of patients recovering from cardiac arrest appears to bear a direct relationship to the ease with which the causative factor can be removed.

Although this paper is concerned with the patient, it must be recognized that there are three principal components in the cardiac arrest situation: In addition to the state of the patient, there is the surgeon and the surgery undertaken, and there is the anesthetist. A widely experienced surgeon has said that surgeons must bear some of the responsibility for the rising incidence of this disaster. He has pointed out that the surgeon's insistence on a cadaveric degree of relaxation when it is not truly necessary, the surgeon's insistence on speed of induction (and the anesthetist's perhaps too ready acquiescence in the almost frantic haste that all too often attends readying the patient for surgery), and finally the surgeon's insistence on very steep Trendelenburg position when the patient is not tolerating it well, are all factors in producing cardiac arrest.

For at least two decades there has been a strong and growing belief, especially on the part of able surgeons, that the anesthetist with his increasingly complex and dangerous "modern" routines must bear a large part of the responsibility for cardiac arrest. Others have sensed this too. As long ago as 1938 the distinguished British pharmacologist A. J. Clark, on reviewing the history of anesthesia, came to the puzzled conclusion that the "progress" he found led to an increase in anesthesia deaths. He said, "The fact that deaths under anaesthesia are increasing rather than decreasing indicates that we are far from having attained perfection."

Admittedly it is difficult to pinpoint the anesthetist's responsibility in most cases. Some data are very hard to overlook (although some appear to have succeeded in doing this). For example, one of us (H. K. B.) with Todd [2] showed in a series of cases collected from 10

leading university hospitals over a five year period that the number of deaths during induction of anesthesia in a very large series was over five times as great when the muscle relaxants were used as when they were not used. However unpleasant these data are, it seems to us that they had better be faced as an example of the anesthetist's share in the responsibility for these deaths. Even so, it is not our view that this record requires the elimination of these valuable agents. On the contrary, it is our belief not only that the technical use of the agents has already been improved but that better agents are being and will be produced. Our reasons for not standing aside from the important development of the muscle relaxants has been stated in detail elsewhere.[3] Other well-documented examples of the anesthetist's responsibility could be cited. The above is enough to illustrate the point that the patient, the surgeon, and the anesthetist all contribute to the problem. Its solution requires improved information or action from all three sources.

It is not within the scope of this report to enter into a discussion of the treatment of this emergency; however, it is our observation that immediate diagnosis, prompt thoracotomy and manual systole, artificial respiration with oxygen, and judicious use of drugs are essential for recovery in cases of cardiac arrest. It is not our practice to delay these procedures for needling of the heart, administration of drugs, or securing of electrocardiographic equipment. We do not advocate subdiaphragmatic massage.

Conclusions

Cardiac arrest is the major cause of operating room deaths, and there has been an absolute increase in the incidence of this emergency in recent years. This recorded increase is due to the current awareness of the problem, leading to an increased frequency in its diagnosis, and the increased number of surgical procedures carried out in elderly and decrepit patients. Cardiac arrest has been shown to be more common in old patients (twentyfold), in poor risk patients (thirtyfold), and in patients with heart disease (fivefold) than in others. Additional contributory factors are deepening anesthesia, hypoxia, reflex phenomena, and improper choice or management of anesthesia. During the last 10 years the recovery rate in cardiac arrest was 37%, and during the last 5 years the recovery rate was 50%.

1. Deleted on proof.
2. Beecher, H. K., and Todd, D. P.: A Study of the Deaths Associated with Anesthesia and Surgery Based on Study of 599,548 Anesthesias in 10 Institutions 1948-1952, Inclusive, Ann. Surg. 140: 2-34 (July) 1954.
3. Beecher, H. K.: Deaths During Anaesthesia, Lancet 267: 922 (Oct. 30) 1954. Beecher and Todd.[2]

SURGICAL ALLEVIATION OF PARKINSONISM

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• The complete incapacitation seen in severe cases of Parkinsonism is illustrated by five case histories. In one instance the tremor, rigidity, and deformity were such that the patient could not even sit unsupported and had been 100% helpless for 25 years.

Surgical occlusion of the anterior choroidal artery was attempted in 50 such patients, and in 30 there was alleviation of both tremor and rigidity in the contralateral extremity. In some cases the patients have not only become ambulatory and capable of self-care but have also resumed employment. Chemical destruction of a region in the globus pallidus was attempted in a second series of 50 patients. The technique includes meticulous orientation of a cannula by means of pneumoencephalography, verification of the site by injecting procaine to observe effects in the contralateral extremity, and final injection of alcohol to destroy the active focus. Good lasting results were obtained in 32 cases.

Analysis of complications and failures will improve the methods of selecting patients and lessen the risks of operation. It is demonstrated that the tremor, rigidity, and deformity can be relieved, without loss of motor power, in long-standing, far-advanced cases.

It is the purpose of this report to summarize the current status of an investigation of two new neurosurgical techniques used in the treatment of far-advanced Parkinsonism. These techniques are surgical occlusion of the anterior choroidal artery, which has now been used as an investigative technique for two and one-half years in a series of 50 cases, and chemopallidectomy, which consists of nonstereotaxic injection of either anesthetic or neurolytic agents into the region of the globus pallidus, with use of a pneumoencephalogram to aid in orientation of the cannula.

Chemopallidectomy has been under investigation for one and one half years and has also been utilized in a series of 50 cases. The data and experience that have been accumulated from these 100 cases constitute the material upon which this report is based. Each of the 100 cases has been documented by motion picture films taken prior to surgery and at periodic intervals after operation.

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This is a revision of a paper read by Dr. Cooper in conjunction with a motion picture demonstration before a meeting of the Harvey Cushing Society, Quebec, Canada, May 17, 1955.

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The pallidectomy guide described in this paper will be available from the Codman and Shurtleff Surgical Instrument Co., Boston.

Occlusion of Anterior Choroidal Artery

Rationale.—The technique of purposeful surgical occlusion of the anterior choroidal artery evolved serendipitously as a result of the unintended sacrifice of this

vessel when it was torn during an operation originally intended as a pedunculotomy in a case of unilateral Parkinsonism.[1] The hypothesis, developed subsequent to this surgical accident, was that the anterior choroidal artery might be the principal source of blood supply to the globus pallidus and related extrapyramidal nuclei, which, when diseased, contribute actively to the development of Parkinsonian tremor and rigidity; subsequent surgical investigation was based upon this hypothesis.

Technique.—The technique, as developed up to the present time, is as follows. Cerebral arteriography is performed prior to operation in order to visualize the anterior choroidal artery and to determine its point of origin, relation to the posterior communicating artery, course, and configuration.[2] General anesthesia was used in the first 25 cases in this series. Postoperative somnolence, morbidity, and pneumonia were almost invariable. Local anesthesia has been used in the second 25 cases, with marked improvement in the postoperative course of these patients. Occasionally, the local anesthesia is supplemented with 0.2% thiopental (Pentothal) sodium administered intravenously, but we limit the total amount administered to less than 200 mg.

After 80 to 100 cc. of cerebrospinal fluid has been drained by the lumbar route, the patient is placed on the operating table in the lateral position with the head dependent. The temporal lobe is gently elevated, exposing the edge of the tentorium and arachnoid of the basilar cisterns. At this point, an intravenous infusion of 15 grains (1 gm.) of papaverine hydrochloride or dioxylene (Paveril) phosphate in 1,000 cc. of 5% glucose is started to aid in prevention of spasm of the internal carotid artery and its branches during the subsequent dissection. The arachnoid is opened anterior to the oculomotor nerve. The single factor that has offered the greatest difficulty in this part of the dissection has been adhesions of the uncus to the arachnoid and oculomotor nerve in some of the patients with postencephalitic Parkinsonism. After the arachnoid is opened, the carotid, posterior communicating, and anterior choroidal arteries are identified. The anterior choroidal artery is coagulated about 1 mm. from its origin and again 1.5 cm. distally. Complete dissection until the artery is gray and shriveled is essential. In our own experience, silver clips alone will not suffice to ensure complete and permanent obliteration of the vessel, and electrocoagulation must be used. The wound is closed without drainage, and the papaverine hydrochloride infusion is allowed to run slowly for the next three to four hours.

Results.—Of the 50 operations performed, 30 operations, or 60%, yielded good or excellent results, signifying alleviation of both tremor and rigidity in the contralateral extremities. Twelve operations (24%) were failures. The mortality rate was 10%, and there were three cases (6%) of hemiplegia. One of the patients suffering from hemiplegia had a moderate degree of aphasia and also suffered a severe, reactive depression. There were five instances of oculomotor nerve palsy, all of which cleared spontaneously, and one case of quadrantic hemianopsia. Two patients demonstrated choreiform movements for one week postoperatively. Many patients were disoriented during the immediate postoperative period, and two had formed visual hallucinations during the first week. Intensive psychological studies have failed to reveal any lasting postoperative intellectual impairment in these patients. Of the 12 failures, 5 were due to technical failure to obliterate the anterior choroidal artery.

To illustrate results that have been classified as good or excellent, five cases will be briefly cited. These cases, originally reported in 1953 and 1954, are intentionally cited here to afford an opportunity for follow-up consideration of these same cases.

Report of Cases

Case 1.—A 36-year-old man with bilateral rigidity and tremor of 18 years' duration had been vegetative and bedridden and in a state hospital for 4 years prior to operation. He could not stand or walk alone, turn over in bed, or feed himself. The left anterior choroidal artery was ligated in February, 1953, and the right anterior choroidal artery in March, 1953. Since the second operation the patient has been ambulatory and independent. He is free of tremor and rigidity on the left side, and his symptoms are markedly alleviated on the right. He has been discharged from the state hospital and lives alone in a hotel.

Case 2.—A 59-year-old man had bilateral postencephalitic Parkinsonism of 25 years' duration. He had not worked for 17 years and was a nursing problem and nonambulatory for 8 years. Since occlusion of the right anterior choroidal artery 23 months ago, the left extremities have been completely free of tremor and rigidity, with motor power more marked than preoperatively. He is now completely ambulatory and capable of self-care.

Case 3.—A 51-year-old man with bilateral tremor and rigidity was discharged from his position because of the incapacitation of Parkinsonism. In July, 1953, the right anterior choroidal artery was occluded, with relief of tremor and rigidity on the left side and considerable improvement on the right side as well. He is once again employed in the same type of work and has maintained all improvements to the time of writing.

Case 4.—A 41-year-old male had been 100% helpless from postencephalitic Parkinsonism for 25 years. He could not walk, talk, or sit unsupported and could swallow only puréed foods. After coagulation of the right anterior choroidal artery 20 months prior to the time of writing, he had complete relief of tremor, rigidity, and deformity of the left extremities and has been ambulatory and capable of self-care to the time of writing.

Case 5.—A 53-year-old woman with marked bilateral tremor and moderate rigidity had become incapacitated and had to have an attendant and housekeeper at home. Since occlusion of the right anterior choroidal artery one year prior to the time of writing, she has been free of tremor and rigidity on the left side and does her own housework, manages a small garden, and drives her own car.

It has been obvious from the inception of this investigation that there are certain inherent disadvantages in this technique, the most obvious of which is the variability of the origin and distribution of the anterior choroidal artery. However, the results in this series have been more consistent than originally anticipated. Moreover, certain of the results in completely disabled and deformed patients have demonstrated the surgical reversibility of what previously appeared to be hopeless and irreversible stigmas of Parkinsonism. In addition, more than 25 neurosurgeons have now confirmed the efficacy of the procedure, although many, like us, have encountered difficulties and complications during their investigations.

Chemopallidectomy

One of the procedures that was originally used to help select patients for operation was direct injection of procaine into the globus pallidus to see whether procainiza-

tion of this region might alleviate contralateral tremor and rigidity.[3] This technique proved to be so simple that it was decided to use it in order to localize a physiological landmark, the permanent destruction of which might yield lasting relief of contralateral tremor and rigidity. This led to a second technique, which we have called chemopallidectomy.[4] The technique has been changing and evolving in a series of 50 cases. As presently performed, the technique is as follows.

We have found that if a trephine opening is made immediately above the zygoma, and a cannula inserted at an angle aimed at the top of the third ventricle, the cannula will consistently pass through the mesial globus pallidus at a depth of 4.5 to 5.5 cm. from the cortex (fig. 1). Therefore, to determine the route of the cannula to the globus pallidus, a pneumoencephalogram is performed with 20 to 30 cc. of air introduced by the lumbar route. Prior to radiography, two radiopaque landmarks are placed on the scalp, one at the site of

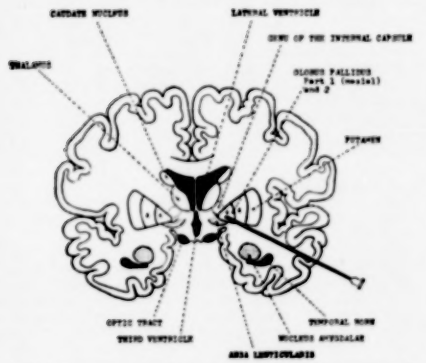

Fig. 1.—Diagrammatic cross section through the cerebrum, demonstrating the route used for puncture of the globus pallidus.

the proposed trephine and the other 9.5 cm. from the midline on the contralateral side. A line drawn between these points will usually pass immediately above the third ventricle and indicate the plane of cerebral puncture (fig. 2*A*). However, it is possible, after viewing the first pneumoencephalogram, to change the contralateral landmark until the proper plane is achieved in which to guide the needle. The usual level in the sagittal plane lies 14 cm. behind the nasion, although this plane is also checked pneumoencephalographically so that it lies 5 mm. behind the foramen of Monro (fig. 2*B*).

When a polyethylene cannula has been properly placed so that its tip lies in the region of the mesial globus pallidus, 0.25 cc. of 1% procaine is injected. Usually this will immediately relieve tremor and rigidity of the opposite extremities, thus confirming this "physiological landmark." When this confirmation is attained, 0.4 cc. of dehydrated alcohol is slowly injected over a 20-to-30-minute period. The wound is closed with the cannula remaining in place, and two more injections of absolute alcohol are made during the ensuing week to enlarge the lesion and ensure a lasting result. The polyethylene cannula has a stylet with radiopaque marks every centimeter that allows one to check the exact position of the cannula radiographically prior to injection. In order to standardize this simple procedure we have developed a needle guide for use in chemopallidectomy. This needle guide utilizes the landmarks described

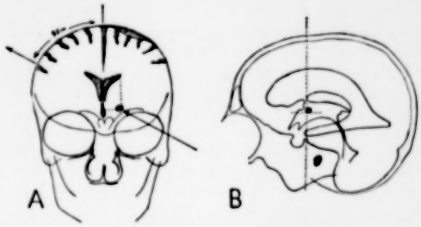

Fig. 2.—*A*, diagrammatic representation of the anterior posterior pneumoencephalogram, demonstrating landmarks used to locate plane of cerebral puncture for globus pallidus injection. *B*, diagrammatic representation of lateral pneumoencephalogram, demonstrating ventricular landmarks that are used during chemopallidectomy.

above and provides a simple and accurate means for globus pallidus puncture (fig. 3). The operation of chemopallidectomy has been performed 50 times. There have been four serious complications resulting in two deaths, one case of hemiplegia, and one occurrence of ataxia and oculomotor nerve palsies. The over-all incidence of good lasting results is 65%, and it has been higher in the latter half of the series. Chemopallidectomy is a simple and extremely promising technique. It is capable of relieving both tremor and rigidity without any compromise of motor power. This experience and the experience of others [5] demonstrates the value of surgery of the globus pallidus for the alleviation of Parkinsonism.

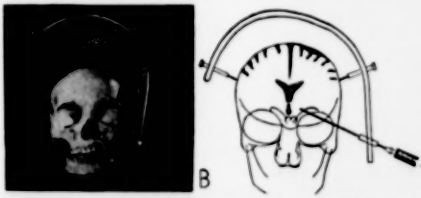

Fig. 3.—*A*, photograph of pallidectomy needle guide developed for standardization of technique of globus pallidus puncture. *B*, diagrammatic representation of needle guide in place after pneumoencephalography. When pneumoencephalography, with the needle in place, demonstrates the needle to lie in the region of the globus pallidus, physiological confirmation is achieved by injection of 0.25 cc. of 1% procaine. If localization is correct, immediate cessation of contralateral tremor and rigidity will result. More permanent destruction can then be carried out.

Conclusions

It is not the purpose of this report to suggest that either or both surgical occlusion of the anterior choroidal artery or chemopallidectomy should necessarily become standard procedures in the treatment of Parkinsonism. However, it has been demonstrated that even the patients with the most far-advanced cases and those who are most disabled have conditions potentially amenable to surgical

therapy. It has also been shown that relief of rigidity, tremor, and deformity can be achieved without sacrificing motor power. It is concluded that further efforts are justified to improve these and other surgical techniques aimed at the mesial globus pallidus, to improve methods of selection of patients, and to lessen the risks of operation. The possible avenues of approach seem clear-cut, and, as in lobotomy, many variations of technique will doubtless be possible. It is anticipated not only that improved surgical therapy will ensue during the further development of these techniques but also that some contribution will be made to an improved understanding of the pathological physiology of hyperkinetic disease. The gravity of the problem and the present deficiencies of medical therapy, as well as the results of this and other studies, appear to justify intensive and studious efforts in this direction.

Addendum

In the year since this paper was prepared, the number of patients treated with chemopallidectomy has been increased to 125. Good results have been obtained in 70%. Moreover, the additional period of follow-up of the early successful cases of occlusion of the anterior choroidal artery and chemopallidectomy has demonstrated that the good results are enduring.

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MANAGEMENT OF ALKALI BURNS OF THE ESOPHAGUS

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• ***Alkali burns of the esophagus were seen in 233 patients within 25 years in a single hospital. Most of these burns came from drinking lye, and 188 of the patients were children less than 6 years old.***

Stricture followed in most cases, commonly within two months but sometimes more than a year after the accident. It was present at the time of admission in 170 patients. The upper third of the esophagus was the most frequent site.

Of 206 patients with resultant severe esophagitis, 188 responded to esophageal dilatation; 14 required surgical excision of the stenotic portion. Dilatation must be carried out with due caution, since perforation is disastrous. The five deaths ascribed to perforation all occurred before 1939.

Further efforts should be made to educate the public to the dangers of commercial cleaning agents that may be ingested by children.

Unfortunately, alkali burns of the esophagus are still encountered with regularity, particularly in the South, where lye is used as a household cleaning agent. Commercial lye preparations contain 95% sodium and potassium hydroxide and are used for cleaning and making soap. In solution this material is easily mistaken for milk by children. The management of the acute alkali lesion of the esophagus is directed primarily toward the prevention of subsequent esophageal stricture. There is still considerable controversy as to the value of esophageal dilatation in the acute and chronic stages of this injury. The length of time treatment should be continued before surgical resection of the stricture is not clearly defined. The study of these problems prompted this report of 233 patients with alkali burns of the esophagus seen at Duke Hospital during the past 25 years.

Clinical Material

In this study of 233 cases of alkali burns of the esophagus, 95% resulted from the ingestion of commercial lye solutions. Of the entire group, 80% were children under the age of 6 years (table 1). The blame could usually be placed directly on the parents, who carelessly left lye in a familiar container within reach of the child. About 10% of the burns resulted from attempted suicide and occurred in patients over 16 years of age.

A total of 74% of the patients were not seen until esophageal strictures had developed. In 85% of our patients with strictures, the insidious onset of recurrent dysphagia developed 14 or more days after the ingestion of alkali (table 2). This "latent phase" was not appreciated by the attending physician, and an unnecessary delay was incurred in starting early dilatation therapy. Esophageal strictures were found most frequently in the upper third of the esophagus (table 3). In 32 patients there was more than one stricture. Of the 14 patients who required direct surgical relief of their persistent obstruction, 5 had involvement in the upper third, 7 in the middle third, and only 2 in the lower third of the esophagus. A squamous cell carcinoma developed at the site of the lye stricture in two patients. In one patient the lye had been ingested 43 years before and in the second patient 18 years prior to discovery of the tumor.

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A clinical classification of the degree of injury to the esophagus was made according to the patient's clinical appearance, x-ray and esophagoscopic studies, and the response to treatment (table 4). Ten per cent of the patients had mild esophagitis and did not require dilatations; 16% had severe esophagitis and were seen within 48 hours after ingestion of the alkali solution. This group received oral antegrade esophageal dilatations, starting on the fourth to the seventh day. A total of 6% of the 233 patients ultimately required surgical removal of the stricture.

TABLE 1.—*Age of Patient at the Time of Ingestion of Alkali*

Age, Yr.	No. of Patients	%
0-1	11	4.7
1-2	114	48.3
2-5	65	27.7
6-20	20	8.6
20 or over	25	10.7
Total	233	100.0

Treatment

Acute Phase.—Patients in the acute phase were not seen for several hours after ingestion of the caustic; therefore, attempts at neutralization of the alkali were not practical.[1] All patients with acute alkali burns of the esophagus, comprising 24% of the total, were hospitalized immediately. The esophagus was placed at rest by deferring oral feedings for several days. Fluids were given parenterally, and antibiotics were used to control infection. After the acute inflammatory process had begun to subside on the fourth to the seventh day, a soft rubber eyeless catheter filled with mercury was passed without force into the stomach.[2] For children a no. 10 to no. 34 F. catheter was used, and for adults dilatation was continued to a no. 40 F. catheter. If a stricture developed, a gastrostomy was performed and retrograde dilatations were then started.

Chronic Phase.—A total of 74% of our patients were admitted with an established stricture. After x-ray localization of the stricture and esophagoscopy, a decision then was made whether to do antegrade dilatation or to do a gastrostomy and retrograde dilatations. In 95% of this group of patients retrograde dilatations were required. The Tucker method [3] was used, and treatment was continued until patients were able to eat a normal diet for approximately six months without intervening dilatation of the esophagus. If x-ray studies and esophagoscopic examination at this time showed a functional correction of the stricture, the gastrostomy was then allowed to close. If obstructive symptoms recurred after this trial on dilatation, surgical excision of the stricture was advised. The average number of retrograde dilatations required by this group of patients was 35, and they were administered over a 24-month period.

TABLE 2.—*Time Interval After Ingestion of Lye Before Onset of Persistent Obstructive Symptoms*

Interval, Mo.	No. of Patients
0-½	28
½-1	53
1-2	40
2-3	23
3-12	31
Over 12	15
Total	190

Indications for Excision of the Stricture

Resection of the severely burned esophagus is a formidable procedure.[4] Because of the extensive shortening and periesophageal inflammation, extensive surgical mutilation of the intestinal tract may occur. Eleven patients had an esophageal resection with esophagogastrectomy, with one postoperative death. In three cases it was possible to do a local resection of the stricture with esophagoesophagostomy or esophagoplasty (table 4). The indication for surgery in 11 of our cases was failure of the stricture to respond to retrograde dilatations. In one patient resection was done for complete obstruction due to a foreign body perforating the esophagus at the site of a stricture and in two because of carcinoma of the esophagus in the strictures.

Results of Treatment

The results of treatment are outlined in table 4. In 24 patients with mild esophagitis no esophageal dilatation was required, and follow-up studies revealed no subsequent dysphagia in this group. The 36 patients with severe esophagitis were seen within 48 hours after ingestion of alkali. They were treated with an average of 35 early antegrade dilatations, and only four, or 11%, developed esophageal strictures. In the four patients who developed esophageal strictures, a gastrostomy was performed and retrograde dilatations instituted. Each patient responded without permanent obstruction. All of the patients in this group have been followed a minimum of three years and are able to take normal diets without further dilatations.

TABLE 3.—*Location of Esophageal Stricture*

Location	No. of Patients
Upper third	60
Middle third	40
Lower third	36
Upper and middle third	8
Upper and lower third	13
Middle and lower third	13
Total	170

In the majority of our patients, the stricture had developed prior to admission to the hospital, and these patients were treated with antegrade or retrograde dilatations, depending upon the degree of stricture. Many antegrade failures in this group subsequently responded to retrograde dilatations. Of 170 patients admitted with an established esophageal stricture, 82% responded satisfactorily to antegrade or retrograde dilatations and are able to eat normal diets. There were 14 refractory strictures that required surgical excision. One death occurred in an esophageal resection with esophagogastrostomy due to postoperative aspiration and asphyxia. All three of the patients who had local resections with an esophagoesophagostomy or esophagoplasty required postoperative esophageal dilatation. In 3 of the 10 cases

in which esophagogastrostomy was done, postoperative dilatations were required because of stricture thought to be due to reflux esophagitis.

At the time of writing, 22 patients were receiving esophageal dilatations. Seven had burns of less than 12 months' duration; seven are candidates for esophageal resection; and eight patients are receiving occasional oral dilatation by their physician or parents. Twenty of our 233 patients died during the course of treatment or of complications arising from esophageal obstruction (table 5). There have been only two deaths since 1943, one due to aspiration pneumonia at home and one operative death. The marked reduction in mortality since 1943 is due to the use of antibiotic agents in preventing mediastinitis following instrumentation accidents and the control of aspiration pneumonia.

TABLE 4.—*Data on Alkali Burns of the Esophagus*

Clinical Classification	Treatment	Results	No. of Patients
Mild acute esophagitis	No dilatation	Excellent; no dysphagia	24
Acute severe esophagitis	Early antegrade dilatations	Good; 4 required subsequent retrograde dilatations	36
Fibrous stricture on admission	Antegrade and/or retrograde dilatation	Eating normal diet	134
		Modified diet with occasional dilatation	13
		Requiring regular dilatations	9
Acute severe esophagitis with perforation of esophagus	Supportive therapy; all admitted prior to 1939	Died shortly after admission	3
Refractory esophageal strictures	Esophageal resection with:		
	Cervical esophagoplasty	Good result after postoperative dilatation	2
	Esophagoesophagostomy	Postoperative dilatation	1
	Esophagogastrostomy	Good results	7
		Required postoperative dilatations; with good results	3
		Operative mortality	1
		Total	233

Comment

There is general agreement that esophageal dilatation is of value in the treatment of caustic burns of the esophagus. The major dispute has been when to start the dilatation therapy and how long to persist in efforts to maintain a satisfactory esophageal lumen before resorting to surgical excision of the stricture. Up until 1925, late bougienage was most often used. The esophagus was allowed to heal and dilatations were started about three to five weeks after injury. This method of treatment carried a high mortality rate, as the risk of perforating the esophagus at this stage was great. Advocates of late dilatation hold that sounding in the acute stage maintains the inflammatory changes, which give rise to increased production of scar tissue. This method of late bougienage is championed by Vinson,[5] Bajkay,[6] Belinoff,[7] Stumboff,[8] and others.

Johannessen [9] in 1899 proposed that intermittent early bougienage should be started before a stricture had time to develop. Salzer [2] standardized the method of early dilatation and in 1934 reported a series of 180 cases with 90% good results. This method quickly gained many adherents in this country, and enthusiastic reports were made by Martin and Arena,[10] Crowe,[11] Kernodle,[12] and others.

The recent experimental studies of Krey [13] and Burford [14] indicate that actual stricture formation begins on about the 15th day following ingestion, as collagen fibers begin to contract. This would indicate that early dilatation could perhaps be delayed until this time without loss of esophageal elasticity.

Theoretically, early esophagoscopy should be of great value in deciding the course of therapy to be used in acute corrosive esophageal burns. Belinoff [7] classified his series of about 800 cases into three groups according to the degree of severity of the lesion as determined by early esophagoscopic examination. Our own experience with early esophagoscopy in the acute stage has been too limited for us to be able to classify with accuracy the degree of the burn.

Of 170 patients with established esophageal strictures who required antegrade or retrograde esophageal dilatation, 82% have an adequately functioning esophagus. Fourteen patients required surgical excision of the esophageal stricture, and there was one postoperative death. In 6 of our 14 cases in which resections were done, postoperative esophageal dilatation was required, and 3 of 11 patients with esophagogastric anastomosis developed what was thought to be reflux esophagitis. Burford and others [14] have stated that dilatation of esophageal strictures after lye burns is not the treatment of choice. They feel that, if the stricture cannot be dilated initially after two or three attempts, a resection of the esophageal stricture should be performed. We must disagree with this, as we have seen patients who required 25 to 30 dilatations before an adequate-sized esophagus was obtained. The operative mortality and postoperative morbidity of esophageal resection cannot be minimized. The development of postoperative peptic esophagitis is a problem when the cardiac sphincter mechanism is destroyed by operation. Postoperative peptic esophagitis occurred in 13% of all patients who had esophagogastrectomies performed at Duke Hospital and in 25% of patients who had esophagojejunostomies.[15] It is doubtful that substitution of jejunal or colonic segments for the esophagus will prevent peptic reflux ulceration, and, if the stomach is removed or bypassed, a marked postoperative nutritional problem results.

TABLE 5.—*Causes of Death in Cases of Esophageal Alkali Burns*

	No.
Perforation of esophagus after attempted esophageal dilatation or esophagoscopy (all prior to 1939)	5
Acute periesophagitis or mediastinitis from erosion of the esophagus	3
Aspiration pneumonia	3
Operative death from esophageal resection	1
Carcinomatous change in old stricture	1
Unknown causes after discharge	7
Total	20

In reviewing the records of the 14 patients who required surgical excision of their esophageal stricture, it is evident that they are the group with the severest burns or ones who had localized deep circumferential burns.

This may give some insight as to which lesions will respond to dilatation and which ones will not. If there is ulceration of the esophagus on only one side of the esophageal lumen, esophageal bougienage results in dilatation of the normal esophagus opposite the area of scar tissue rather than the resistant contracting scar. When a deep circumferential burn occurs, the possibility of its responding to dilatation is much less, since there is no normal esophagus that can be readily dilated. The alarming number of cases of caustic burns of the esophagus reviewed here is evidence that not enough has been done to educate the public to the danger of common household lye.

Summary

A total of 233 cases of caustic alkali burns of the esophagus was reviewed. In 80% of cases the patients were children under 6 years of age; 95% of cases resulted from ingestion of lye. The 24 patients (10%) who had mild esophagitis required no esophageal dilatations. There were 34 patients (15%) with severe esophagitis who were seen within 48 hours after ingestion of alkali and received early antegrade dilatations. Four of these patients developed a stricture but subsequently responded to retrograde dilatations. Of 170 patients admitted with established esophageal strictures, 82% responded to esophageal dilatations. Of 206 patients with severe caustic esophagitis, 188 (91%) responded to antegrade or retrograde esophageal dilatations. An adequate trial of dilatation therapy should be administered before surgical resection is advised. Further efforts should be made to educate the public to the dangers of commercial cleaning agents in order to reduce the incidents of esophageal stricture.

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THE PHYSICIAN AND THE PUBLIC HEALTH DEPARTMENT

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Of all the voluntary and governmental health agencies confronting the physician during his daily practice, the one with which he probably has the most contact is the one he appears to know the least about. Before one can endeavor to formulate a relationship of practicing physician to the public health department, one must first explore the apparent abyss that seems to exist between these two branches of the same profession. As one ventures deep into this situation, he finds the differences of opinion that do exist are based almost solely on a lack of understanding on both sides of the function each party is prepared to perform. Some of these misunderstandings, while based on lack of knowledge, do have a fairly good basis due to past experience. Many medical schools in the past have presented the health department as a bumbling, bureaucratic agency interfering in the medical field. Too often graduating medical students envision the health department as existing only because it has to fulfill certain legal and necessary functions that have no direct bearing on the actual practice of medicine other than the registration of birth and death certificates and the useless accumulation of morbidity statistics.

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• *The work of the average health department can be divided into two major functions to present the way it works best with the physician; namely, epidemiology and health education.*

Epidemiology includes the control of communicable disease, which depends on the interchange of information between physician and health department, the elimination of routes of disease transmission, and the carrying out of such preventive measures as immunization. The health department provides laboratory facilities and other valuable services in this connection.

Health education programs reinforce the efforts of the busy physician to educate his patients and the community at large in accepted preventive health practices. Problems of child health, venereal disease, food handling, and tuberculosis are a few examples of this work.

The practicing physician identifies himself with the local health program in various ways, but especially through the public health committee of the local medical society. In order to have a health department that is an asset to the community and to the profession, the physician must advise, criticize, and participate, both as an individual and as a member of his local medical society.

When it comes to the health officer's interpretation of private practice, his approach seems to be quite a paradox. After all, he usually is a doctor of medicine and has gone through the same medical school as the practicing physician. In both cases, it seems easy to suggest an improvement for the future. In the case of the health officer, let him endure a few years of private practice before entering the field of public health. In the case of the medical student, and the physician now in practice, let a well-trained public health officer explain public health in the light of how the health department works, not only in the private physician's behalf, but also as a close ally in all phases of his medical practice. It is this approach that this article will attempt to offer. The health department should be part of the doctor's medical equipment in providing the highest quality medical service available. As long as there are diseases that may be transmitted from person to person, or transmitted by the environment, it cannot be expected that the family physician can contribute sufficient time or personal funds to cope with all the medical problems that affect the community at large. It is here that governmental bodies, with the backing of the medical profession, have found just cause for creating such official health agencies as would have the time, personnel, and money to protect citizens from those illnesses for which there is some form of prevention through environmental control.

Before going into the mode of preventive medical operations, it must be stated that the most effective health department does not treat illness or partake directly in any form of medical care. The medical care service of a health department should be limited to fulfilling educational needs of the public, as to why, how, and when to obtain proper care. Public health has always been synonymous with preventive medicine, and it is in this field of endeavor that its functions should be concentrated in order to justify the expenditure of public funds over and above that of the welfare department for indigent care. While it is incumbent upon the private physician to practice preventive medicine, statistics show that the average doctor of medicine spends 95% of his time with the illness that is already manifesting itself, or at least believed to be by the patient. No physician will question the fact that prevention should be practiced more, any more than he will further admit he certainly has not the time he would like to devote to such a field and yet still be able to take care of those persons who are acutely ill.

Health Department Functions

While it is known that there are almost as many different organizational patterns for public health administration as there are health departments, it appears feasible to divide the average health department into two main functions to present the way it works best with the physician.

Epidemiology.—The first of these major functions is that of epidemiology, and this might be subtitled communicable disease control. This usually begins with the morbidity report card the physician sends to the health department to report a contagious disease. While regulations differ in many states as to which diseases should be reported, the principle behind disease reporting remains the same. Whether the physician lives up to his obligation of reporting communicable diseases is equally as important as whether he takes advantage of the information compiled by these reports. How often have you wondered whether a specific disease, say one of the many being considered by you at the moment, is prevalent in your community? The answer to this question is usually available in the health department's monthly communicable disease bulletin. Up-to-the-minute information should be available to you with a telephone call to the health officer. The reliability of the figures you do get depends on the previous conscientious cooperation of you, who are requesting these facts, and your colleagues, who may be asking the same question tomorrow. The use of disease reporting does not just end here. It starts into motion certain public health mechanisms to control disease where possible. There are three general areas in which to prevent disease. 1. Disease information, via morbidity report cards, shows where the infected host is and where necessary isolation may be practiced. 2. Certain illnesses are best controlled by eliminating or modifying the route of transmission (e. g., food, water, or insect vectors). 3. Morbidity information gives some idea of the number of susceptibles, so that immunizations, or other preventive procedures, may be inaugurated.

To carry the epidemiological approach to medicine further, most health departments provide diagnostic laboratory services to the physician. In addition to the multitude of examinations now being taken advantage of, there is always that rare disease, the laboratory test for which is economically unfeasible for the private laboratory service. It may be some form of seroagglutination procedure so uncommonly called for that the private laboratory facility does not maintain suitable equipment or reagents. All too often it is felt that the public health laboratory is a medical facility for the indigent; but the physician who has confirmed his diagnosis of, say, tularemia or Q fever well appreciates having such a diagnostic resource. Milk and water testing, to prevent their becoming vectors of disease, also involve intricate laboratory tests.

Where could the physician in private practice find the time to investigate all contacts of his newly found patient with tuberculosis, and ethically place them under proper medical care? The health department's purpose in getting a patient with tuberculosis under treatment is based primarily on protection for the community and secondarily on consideration of the patient as an individual in need of care. Here is a specific example of the team approach toward communicable disease control: A physician reported a gastrointestinal condition in a family and stated he had exhausted all possibilities of etiology other than the water supply. The particular water supply in question, being only a small part of a large municipal water system that had been tested regularly and found to be satisfactory, could be looked upon with only slight suspicion. Detailed investigation by public health sanitarians confirmed the physician's idea, and it was eventually shown where a cross connection from an impure water supply had been illegally attached to the city's public water supply and had affected all houses

radiating from this branch source. Illness, in this case, was cured by the joint efforts of the physician and health department to eliminate the cause.

There are many other phases of health department work in communicable disease control that can only be mentioned here. These might include regulations concerning control of stray dogs, as well as their vaccination to eliminate rabies; the regular surveying of food-handling establishments where certain diseases may be so easily spread to large groups of people at one time; the control of the installation of sewage disposal systems; and other controls too numerous to discuss.

Health Education.—The second major function of a health department might come under the general heading of health education. Where can the physician in private practice find the time to educate his community at large in accepted preventive health practices? He has tried, in vain, to impart ideas to just one stubborn patient. In a sense, it might be said the health department is the only ethical form of advertising the medical profession has, for this department utilizes its capacity for community education by having its citizens seek, and actually take advantage of, competent medical care before chronicity has occurred. By health education, the public is informed of its health needs, based on trained observations of practical past experience, and health needs and health wants are coordinated to become one and the same. Education further includes the factor of the health departments keeping local medical men abreast of how new ideas will directly affect their community. Any physician who recently participated in the poliomyelitis vaccine immunization program well understands this part of a physician-information program.

It might be well here to discuss the oft-questioned child health conference, or well-baby clinic as it was known in the past. When this conference is used solely to interpret normal growth and development to an apprehensive mother, it does more to encourage early proper medical care than any other known educational device. The ideal child health conference utilizes physicians in the immediate vicinity. This serves a twofold purpose: 1. It introduces those patients who are unfamiliar with community physicians to a variety of medical men from whom they may choose when an emergency arises. 2. It provides a means for newly located physicians to become aware of local patient needs and ideas of medical care. When the family physician or pediatrician has the time to perform this education service, in his or her office, the need for the child health conference will no longer exist. As a part of its child health conference services, it should be stated that the health department certainly does not wish to make a fetish out of the giving of free immunizations to all preschool children, but, at the same time, it recognizes its responsibility to the community to secure at least 80 to 90% protection of children through immunization, where proved immunizing agents exist. Once again, where the family physician assumes this responsibility, it, too, is removed from the health department to the doctor's own office.

Where clinical diagnostic services do exist in the health department today, excluding those specifically designated for the medically indigent or welfare cases, a little insight into the program will usually show it was organized to fulfill a public need. Again, as with all similar services, when this need is filled in the physician's office, it should no longer be part of the health department's program. This is not meant to preclude certain clinical services of a diagnostic nature, where the need is originated by the physicians. As a specific example, in the small community, there may be no immediately available chest specialist. Physicians in general practice who wish to cooperate with the health department in making a decision regarding tuberculosis have assisted in the organization of a diagnostic chest service whose base of operations centers at the health department. A physician-specialist in diseases of the chest visits the community at monthly intervals as consultant and aids in arriving at a diagnosis and assisting in follow-up care. Here, again, is the team approach toward protection of the community from the tubercular patient.

In many communities, venereal disease and prenatal clinics are not part of health department services, since all patient problems that would be referable to these types of clinics, whether or not the patients are able to pay for services, are taken care of in the private physician's offices. Community education by the public health nurse is used as the means of getting the pregnant woman under early adequate medical care. The fact that there is no community demand for these services, along with the fact that morbidity and mortality statistics do not reflect a lack of sufficient care, bears out the lack of need for the health department sponsoring such programs. The trained public health nurse working in the schools should be devoting her time to health education and applicable multiphasic screening. When she acts as a teacher of health, not only to pupil but to instructor as well, and not just as a first-aid technician, she, too, helps achieve the mission of the health department. In many other ways, health education, through its vital statistics department, as part of the public health program, provides the only source of certain necessary information that protects the health of the community by showing health levels of a particular area. The teaching of the correct handling of food, presentations on how to improve personal health, and recommendations pertaining to the community as a whole regarding diseases, when they become of epidemic proportions, are a few more examples.

Here have been presented just a few of the ways the health department serves the practicing physician. The advantages these services can provide are proportionate to how much the physician participates.

Physician Participation

There is no need here to go back into the history of how health departments were formed or organized. Patterns of today vary with the community. Rather than discuss the past, let us discuss the present and future. There is no better way to state the importance of physician participation than the following quotation: "Unless practicing physicians are closely identified with such [local health] programs at all stages, they run the risk of being overlooked when the time comes to decide how a given health unit shall function best at the local level."[4]

How does the practicing physician identify himself with the local health program? One of the best ways is the public health committee of the local medical society. In my experience, every problem situation, without exception, that might in any way have an effect on the private practice of medicine has been completely worked out by joint meetings with this committee and health department representatives. One small example may be given. During a poliomyelitis outbreak last year, the question arose as to whether to give poliomyelitis immune globulin to residents of a small, fairly isolated area where three cases of paralytic poliomyelitis had occurred in one week. About 350 persons were involved. After a hastily called meeting of members of the medical society and health department, a definite plan of action was agreed upon by both medical groups. Briefly, it was this. Volunteers from the local March-of-Dimes association distributed information directly to the homes of all persons concerned, explaining the situation, allaying fears, and outlining the procedure of obtaining the gamma globulin injections. The procedure consisted of persons desiring the injections calling their own physician's office the next morning and making an appointment. The individual or family then stopped at the health department on his way to his doctor's office and secured his own supply of the globulin. At the health department, the patient's identity, physician, weight, and other data were recorded, saving the physician some clerical procedures. A check list of eligible patients was in the health department, compiled by the volunteers who visited the homes. Records at the end of that one day showed that all 341 persons who desired the immune globulin received it from their private physician before the day was over. With approximately 20 physicians participating in this project, each physician averaged 17 patients. There was no waiting in line, no loss of personal physician relationship, and no expensive burden placed on any one organization. Every physician in the area was contacted by phone the day before this was to take place, through the cooperation of the physician's telephone-answering service, so that none were at a loss to understand the forthcoming procedure. To be sure, this was only a small segment of a community, but the ratio of 17 to 1, in one day, need not be a burden in any community.

To go back to the public health committee of the medical society, it is not meant to convey the idea that the actions of such a committee of the medical society actually direct the operation of a health department, any more than the society attempts to direct the orthopedist or gynecologist in the performing of his specialized services. It acts as an advisory body to another specialized physician in medical practice, the specialist in preventive medicine. Along this same line, referrals and consultations should be available to the health officer as all other physicians, with the only difference being that the health officer has at least 50,000 to 200,000 "patients" as a whole rather than on an individual basis. Another way a physician can participate in community health programs, excluding his being a member of a voluntary health organization, is his active participation in a community health council, if such exists. Good working relationships here coordinate health projects and prevent duplication.

As an individual citizen in his community, the physician provides the best source of influence for his local governing body in maintaining local health departments, so they best serve the medical needs of his particular area. In essence, the health officer, although he should be essentially an epidemiologist, is primarily a medical administrator. As with any business organization that is operating properly, a good administrator constantly seeks advice and constructive criticism from those who can assist his organization to perform better. In the case of the health department, the public health administrator seeks the consultation of medical men, since medicine is the basis of all health operations. If this assistance is not forthcoming, the administrator is forced to arrive at decisions alone. But, if competent advice and constructive criticism are willingly given, whether by the individual physician or the medical association as a group, there can be no misunderstandings or malfunctionings of public health programs. The community benefits, as does the private physician, when the physician remembers he has the health department as just one more instrument in his bag as he goes about his daily practice.

Summary

Physician-health department relationships, where effective, provide a valuable service to the private physician in his daily practice. There are innumerable ways the practicing physician may utilize the health department as an aid in diagnosis, as a means of communicable disease control, and as a way of educating his patients, as a community, to the intricacies of when, why, and how to obtain competent medical care. In order to have a health department in his community that is an asset to the medical profession, the physician, both as an individual and as part of his local medical society, must advise, constructively criticize, and actively participate in community public health programs.

66 Glenwood Dr.

1. Local Health Units, editorial, J. A. M. A. **147**: 328 (Sept. 22), 1951.

Surgical Dissemination of Carcinoma of Thyroid.—Our present knowledge of cancer is comparable, in many ways, to the knowledge of infectious disease a century ago. At that time, the concept of infection disregarded anything that could not be seen. It is the same today in regard to cancer. Too often we give no thought to the invisible cancer cells which cling to our needles and to our hands and we spread disease as certainly as did the hands of the obstetricians in Vienna's lying-in hospitals. The surgical dissemination of papillary carcinomas of the thyroid is an example. A papillary carcinoma of the thyroid is like a pimple: if it is left alone or treated gently, it is not apt to give much trouble. But if a papillary carcinoma is treated roughly, if it is pricked and squeezed, then, it can become a serious, even a fatal, disease. . . . When a papillary cancer of the thyroid has been disseminated by an inadequate operation, it may be impossible, even by the most radical surgery, to control the disease. . . . This is the kind of cancer that is found in 1 of every 200 thyroids if it is looked for carefully, the kind that rarely causes trouble if left alone but which if cut into may prove fatal. —G. Crile Jr., M.D., The Danger of Surgical Dissemination of Papillary Carcinoma of the Thyroid, *Surgery, Gynecology and Obstetrics*, February, 1956.

RECENT CLINICAL EXPERIENCES WITH SERUM AMINOPHERASE (TRANSAMINASE) DETERMINATIONS

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and
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• *The concentration of glutamic oxalacetic aminopherase in the serum of a series of normal subjects was found to be 10 to 45 units per milliliter. Values within this range were also found in a series of patients with a great variety of cardiac diseases except acute myocardial infarction; in nine patients with this condition the serum aminopherase reached values from 3 to 12 times the normal.*

Slight elevations were noted in elderly patients with prolonged shock in whom there was no demonstrable acute myocardial injury, and one patient with acute rheumatic pancarditis also gave high figures.

High aminopherase values, however, sometimes had extracardiac causes. In two instances they accompanied the necrosis of skeletal muscle resulting from vascular disease of the lower extremities. In 20 patients with jaundice of varying etiology high figures were also obtained, and they seemed to be in proportion to the amount of cellular necrosis found in liver biopsy specimens. Extreme elevation occurred in one patient with infarction of the liver.

A rise in serum glutamic oxalacetic aminopherase (transaminase) level after myocardial infarction has been demonstrated by La Due, Wróblewski, and Karmen.[1] Since a large concentration of this enzyme is also present in skeletal muscle, liver, kidney, and brain, we felt that significant rises in serum aminopherase level might be found in clinical conditions where injury to these tissues occurred. A significant rise in serum aminopherase level in patients with jaundice has been previously reported.[2] This paper is a report on patients with various diseases in whom an elevation of serum glutamic oxalacetic aminopherase level occurred. Serum glutamic oxalacetic aminopherase activity was measured according to the spectrophotometric technique described by La Due and others.[3] The activity of the enzyme is fairly stable, with little change in activity noted when the specimen is kept at room temperature for 24 hours and no change noted in serum refrigerated for 48 hours. Hemolysis increases the serum aminopherase level; this could be ascribed to the liberation of the aminopherase present in red blood cells. Normal controls established in this laboratory ranged from 10 to 45 units per milliliter of serum.

Results

Heart Disease.—Preliminary work has shown normal serum aminopherase levels in a variety of heart diseases. We have found normal values in patients with angina pectoris, calcific aortic stenosis, chronic rheumatic valvulitis, acute pulmonary edema with hypertensive cardiovascular disease, auricular flutter of 48 hours' duration, left bundle-branch block, old healed myocardial infarction (by history and electrocardiogram), idiopathic benign pericarditis, and arteriosclerotic heart disease. Slight elevations were noted in elderly patients with prolonged shock in whom there was no demonstrable acute myocardial injury.

In all instances of acute myocardial infarction diagnosed in this hospital over a four-month period (nine cases), there was an elevation of serum aminopherase levels from 3 to 12 times the normal level, with a fall to normal in two to four days. The pattern that the serum aminopherase level follows after an acute myocardial infarction is represented in figure 1. This particular patient was of unusual interest because of a prolonged bout of chest pain unaccompanied by electrocardiographic changes on the day of hospital admission. A slight elevation in the serum aminopherase level for the first four days of hospitalization is seen in figure 1. During the early morning of the fifth hospital day the patient was seized with a more severe attack of chest pain that lasted for 12 hours without complete relief from administration of narcotics. During this bout of pain there were typical electrocardiographic changes of acute anterior wall myocardial infarction and an associated prompt rise in the serum aminopherase level to 300 units per milliliter. The slight but persistent elevation of serum aminopherase level early in the course of this illness may have indicated necrosis of a small amount of myocardial tissue prior to the subsequent definite infarction.

Eight patients in this series survived their myocardial infarctions; the diagnosis was confirmed at autopsy in the patient who died. One patient with a history of two previous myocardial infarctions was hospitalized with severe substernal pain of eight hours' duration. There were no additional electrocardiographic changes to indicate acute myocardial injury; however, on admission the serum aminopherase level was elevated to 86 units per milliliter. Eight hours later the serum aminopherase level was 56 units per milliliter, and 24 hours after the cessation of the pain the value was 28 units per milliliter. The type of elevation seen in this instance, together with the slight elevation of serum aminopherase level observed early in the illness of the patient whose course is shown in figure 1, shows that small amounts of myocardial cellular necrosis may occur with prolonged angina (coronary artery failure). (Acute anoxia produced an elevation of the serum aminopherase level with a simultaneous decrease in the concentration of aminopherase in the myocardial tissue of the rat. This study conducted in this laboratory will be reported in detail elsewhere.)

One patient with acute rheumatic pancarditis (with readily audible pericardial friction rub) had an initial

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serum aminopherase level of 61 units per milliliter that fell to 20 units 48 hours after the institution of cortisone therapy.

Skeletal Muscle Injury.—Two patients have been studied who had bilateral ischemic necrosis of the legs. The first patient had a saddle embolus at the bifurcation of the aorta, with extensive gangrene involving the legs anteriorly within 6 in. (15.24 cm.) of the inguinal ligaments and posteriorly extending into the buttocks. Preoperative serum aminopherase values were 185 units per milliliter; 24 hours after bilateral amputation with hip disarticulation the level had fallen to 92 units.

The second patient with skeletal muscle necrosis had diabetes of many years' duration. He entered the hospital because of bilateral gangrene involving the feet and distal one-third of the lower legs. The initial serum aminopherase level was 51 units per milliliter; the day after bilateral supracondylar amputation the level was 41 units. The patient did well until eight days postoperatively, when he developed severe abdominal pain,

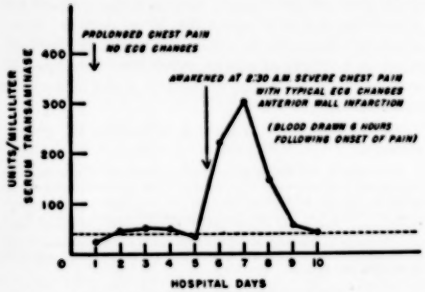

Fig. 1.—Pattern of aminopherase (transaminase) level in patient with acute myocardial infarction.

hypoglycemia, and shock. Despite vigorous supportive measures, the patient died. Eight hours prior to death the serum aminopherase level was 9,150 units per milliliter. Autopsy disclosed thrombotic occlusion of the superior mesenteric artery and celiac axis that had produced extensive necrosis of the small intestine, liver, stomach, and spleen.

In experimental work done on dogs there was small but significant rise in serum aminopherase level after exploratory thoracotomy. This was believed to be due to the associated skeletal muscle injury inherent in the procedure. This finding was confirmed by demonstrating a rise of similar magnitude in human beings at the time of exploratory thoracotomy without additional operative procedures. The elevation persisted from 48 hours to two weeks after operation.

Hepatic Cell Injury.—It has been mentioned previously that there is an elevation of serum aminopherase level in the presence of jaundice.[1] The mechanism of this rise has not been clarified. Three possibilities suggest themselves as causes: the rise might be due to associated hemolysis of red blood cells that contain aminopherase, to regurgitation of bile, or to hepatic cell injury and necrosis. Our clinical experience suggests that the main factor producing this elevation is hepatic cell injury.

Twenty patients with jaundice of varying etiology, including Laennec's cirrhosis, carcinoma of the pancreas with common bile duct obstruction, acute and chronic hepatitis, and infarction of the liver (in association with

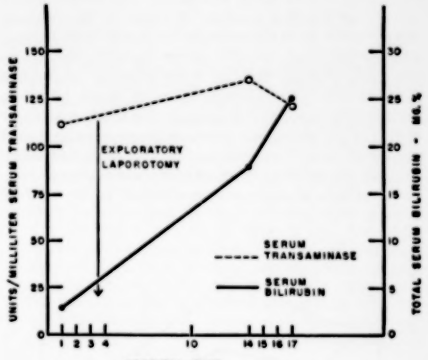

Fig. 2.—Pattern of aminopherase (transaminase) and serum bilirubin levels in patient in case 1 with complete obstruction of the common bile duct due to carcinoma of the pancreas.

necrosis of other abdominal viscera), have been studied. The rise in serum aminopherase levels has been correlated with determinations of serum protein, cephalin flocculation, thymol turbidity, prothrombin time, serum cholesterol, alkaline phosphatase, and serum bilirubin. With the exception of the extreme elevation that occurred in one patient with infarction of the liver, the serum aminopherase values have ranged between 56

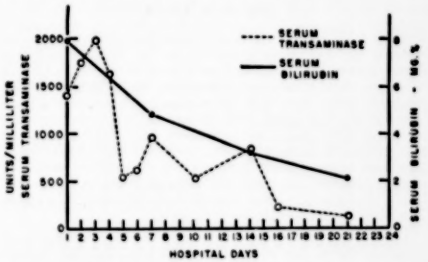

Fig. 3.—Pattern of aminopherase (transaminase) and serum bilirubin levels in patient in case 2 with acute infectious hepatitis.

and 1,900 units per milliliter. The degree of elevation of serum aminopherase level seems related directly to the amount of cellular necrosis observed by microscopic study of the liver biopsy specimens obtained in these patients. Patients with common bile duct obstruction and progressive rise in serum bilirubin levels from 5 to 20 mg. per 100 cc. did not have an associated rise in serum

aminopherase levels, which stayed fairly constant at about 100 units per milliliter.

In order to rule out the possibility that the rise in serum aminopherase level might be caused by regurgitation of bile, human bile was tested for aminopherase activity. The specimens of bile that were studied were obtained from T-tube drainage and were contaminated with pancreatic and duodenal secretions. The aminopherase activity of the bile samples obtained in this manner ranged from 25 to 60 units per milliliter. This finding, coupled with the fact that serum aminopherase levels are fairly constant in cases of extrahepatic obstructive jaundice with progressive elevation of serum bilirubin, excludes the possibility of regurgitation of bile as a major source of the elevation of serum aminopherase level seen in liver disease. Three case histories are presented below to illustrate the wide range in serum aminopherase values that are associated with different types of liver disease.

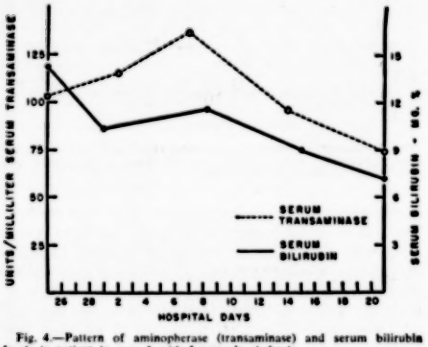

Fig. 4.—Pattern of aminopherase (transaminase) and serum bilirubin levels in patient in case 3 with Laennec's cirrhosis.

Report of Cases

Case 1.—A 63-year-old man entered the hospital because of pain in the right upper quadrant and left shoulder that had lasted for three months. One week prior to admission he had noted the onset of jaundice, light-colored stools, and dark urine. Physical examination disclosed moderate jaundice, with a large mass in the right upper quadrant that was interpreted as being a dilated gallbladder. An exploratory laparotomy because of the obstructive jaundice revealed a primary adenocarcinoma of the pancreas, with direct extension into the common duct, producing complete occlusion. The rapid elevation in serum bilirubin level over a 17-day interval with little change in serum aminopherase level is shown in figure 2.

Case 2.—A 63-year-old man entered the hospital because of jaundice starting one week before admission. This was accompanied by drowsiness and lethargy, but anorexia, nausea, vomiting, and other symptoms were not present. Examination revealed a liver that was nontender and smooth and extended 3 cm. below the right costal margin. Laboratory data suggested infectious hepatitis, and a liver biopsy showed mononuclear cell infiltration of the portal triads, with coagulation necrosis and disintegration of liver cells. The parallel fall of the originally elevated serum bilirubin and serum aminopherase levels with recovery is shown in figure 3.

Case 3.—A 43-year-old man entered the hospital because of weakness with known alcoholism and cirrhosis of six years' duration. Despite a period of psychiatric care, he had continued excessive drinking of beer and whisky. Physical examination at the time of admission revealed a drowsy, deeply icteric patient with numerous spider angiomas, ascites, and hepatomegaly. Liver function studies showed marked impairment of function, and roentgenographic studies disclosed esophageal varices. Figure 4 shows the slow fall in the elevated serum bilirubin and aminopherase levels in classic cirrhosis as the result of a long period of rest, abstinence from alcohol, and dietotherapy.

Summary and Conclusions

Our experiences demonstrating a significant rise in serum aminopherase (transaminase) level after myocardial infarction confirm the earlier observations of other workers. Forms of heart disease unassociated with myocardial tissue damage have not demonstrated this rise. Significant elevations have been noted with skeletal muscle necrosis, liver disease, and with infarction of the liver and other abdominal viscera. The high concentration of the enzyme in these tissues led us to believe that such would be the case. We have therefore concluded that elevations in serum aminopherase level are associated with cellular injury of various tissues and are not related specifically to myocardial tissue damage. Since significant elevations in serum aminopherase level do occur in a variety of clinical conditions, the physician must interpret the results of this test in the light of the entire clinical picture.

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1. La Due, J. D.; Wróblewski, F., and Karmen, A.: Serum Glutamic Oxaloacetic Transminase Activity in Human Acute Transmural Myocardial Infarction, Science **120**: 497, 1954.

2. (*a*) Footnote 1. (*b*) Karmen, A.; Wróblewski, F., and La Due, J. S.: Transaminase Activity in Human Blood, J. Clin. Invest. **34**: 126, 1955.

3. Footnote 1. Karmen, A.: A Note on the Spectrophotometric Assay of Glutamic-Oxalacetic Transaminase in Human Blood Serum, Appendix to footnote 2*b*, p. 131.

Antibiotics as Chemotherapeutic Agents.—During the last 15 years several hundred antibiotics have been isolated. Only about 20 of these have found a place as chemotherapeutic agents. These include penicillin, streptomycin, and its chemical derivative dihydrostreptomycin, chloramphenicol, chlortetracycline, neomycin, oxytetracycline, viomycin, tetracycline, erythromycin, carbomycin, bacitracin, tyrothricin, polymyxin, nystatin, trichomycin, and a few others. Some of these antibiotics are used against certain types of diseases and others against other types. Some, like penicillin, are used against a large number of infections caused by various cocci, gram-positive bacteria, and spirochetes. Others, like streptomycin and the tetracyclines, are used against diseases caused by gram-negative bacteria, such as infections of the urinary tract, or those caused by gram-positive bacteria that have become resistant to penicillin. Some antibiotics are specific for certain diseases, such as streptomycin for tuberculosis, chloramphenicol for typhoid fever, and the tetracyclines for typhus fever and other rickettsial diseases. Some antibiotics are given by injection, others by mouth. Some are used for skin, eye, and ear infections, others for generalized infections. As a result of the introduction of antibiotics, most of the diseases of childhood have virtually disappeared, many of the infections of adults have lost their dangerous implications, and the average life expectancy of man has been increased by 10 to 20 years. Tuberculosis, which only 15 or 20 years ago was the number one killer of the human race, is gradually coming under control. The effectiveness of antibiotics in the treatment of true virus diseases and tumors is still uncertain. Many antibiotics cause allergic and other reactions.—Selman A. Waksman, Ph.D., Definition of Antibiotics, *Antibiotics and Chemotherapy*, February, 1956.

NATURAL COURSE OF ACTIVE RHEUMATIC CARDITIS AND EVALUATION OF HORMONE THERAPY

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and
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• *The course of rheumatic carditis in 100 patients treated with digitalis, salicylates, sedation, and symptomatic therapy was compared with its course in 55 patients treated with the hormones corticotropin, cortisone, and hydrocortisone.*

The three hormones were equally effective. In all patients so treated, the signs and symptoms of active carditis were arrested within 24 to 72 hours, and in the majority of patients enlarged chambers were reduced to normal and new precordial murmurs had regressed by the third to seventh day.

A difference was found between the favorable results in the hormone-treated group and the protracted illness with residual cardiac damage seen in every patient in the contratest group. There was no overt evidence of residual damage in 84% of the patients who were having their first attack of carditis and who were treated with hormones.

Rheumatic fever is of major concern because of its selective involvement of the cardiovascular structures. Any therapy that could be demonstrated to prevent or minimize residual cardiac damage merits complete acceptance. Current opinions on the effect of hormone therapy in rheumatic carditis are controversial.[1] This is due in large measure to paucity of data on the usual clinicopathological course as well as to variations in diagnostic criteria, the time of institution, and the adequacy and duration of therapy. The course of rheumatic carditis varies and appears to be self-limited. To evaluate the effect of hormone therapy it is necessary to consider the usual course of carditis. Furthermore, unless active carditis is recognized early and therapy instituted before irreversible damage is sustained, we cannot expect to prevent rheumatic heart disease.

Patients Chosen for Control Group

One hundred records, starting from the most recent, were arbitrarily drawn for analysis from the active files of the cardiac clinic. The only selective factor was an observed attack not treated with hormones. These patients were under continuous, uniform medical supervision at the New York Hospital.[2] Preliminary analyses revealed that these 100 patients had experienced 165 observed attacks of active carditis. These occurred between 1930 and 1955. Symptomatic therapy, sedation, salicylates, and digitalis were given. The ages at the time of attacks ranged from 3 to 18 years; 72 of the attacks were presumably initial and 93 recurrent. To determine whether the incidence and severity of rheumatic fever had changed in recent years, a comparison of the pattern of rheumatic fever at 5-year intervals during the 25 years was made. It may be seen that there is no significant difference in incidence in two consecutive 10-year periods, 1935-1945 and 1945-1955. The severity and duration of rheumatic carditis were remarkably constant from 1930 to 1955 (fig. 1). A comparison of the severity of carditis in relation to the type of associated manifestations revealed carditis to be of moderate severity in the majority of attacks, particularly in those associated with chorea. In one-fourth of the patients chorea was an associated manifestation, in one-half polyarthritis, and in about 12% of the total attacks subcutaneous nodules were noted (fig. 2). These observations are comparable to a similar analysis made in 1948 on a larger series of over 1,000 patients.[3]

To obtain data on the average duration of active carditis, the total duration was estimated for each attack from the day of onset of illness to the day the patient was ambulatory and free from clinical symptoms (fig. 3). It was found to be less than two months in 20% of the attacks, two to four months in 30%, and four months to more than a year in 50%. There is a general impression that the result of therapy must await years of follow-up study before the extent of residual cardiac damage can be evaluated. It is significant that during the follow-up period of three months to 21 years, an average of 9 years, increasing chamber enlargement or the appearance of new murmurs rarely occurred in the absence of an overt attack of active carditis. An analysis of the evolution of new systolic and diastolic murmurs revealed that during active carditis these new murmurs rarely disappeared. During the average follow-up period of nine years, precordial murmurs regressed in one-third of the patients. This is in agreement with the published long-term studies of Wilson and Lubschez [3] and Bland and Jones.[4] These observations in patients receiving symptomatic therapy would appear to be representative of the natural course of rheumatic carditis and to make this group suitable for use as controls.

Hormone Therapy

From 1949 to March, 1955, 55 patients with active carditis of 3 to 21 days' duration were given hormone therapy. At the ages of 4 to 19 years, 25 experienced a presumably initial attack and 30 a recurrent attack. A diagnosis of carditis was made on the following signs and symptoms: (1) poor or distant heart sounds (tachycardia, gallop rhythm), (2) friction rub, (3) new and changing murmurs (systolic or diastolic), (4) increasing enlargement of heart (on physical and fluoroscopic

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The hormone preparations used in this study were supplied by the Armour Laboratories, Kankakee, Ill., the Upjohn Company, Kalamazoo, Mich., and Merck & Co., Inc., Rahway, N. J.

examinations), (5) diminishing cardiac reserve (fatigability, dyspnea, diminishing vital capacity), (6) congestive failure (tender or enlarging liver, increased venous pressure), and (7) electrocardographic abnormalities (increasing P-R interval, S-T changes). A comparison of the symptoms and signs of active carditis in the con-

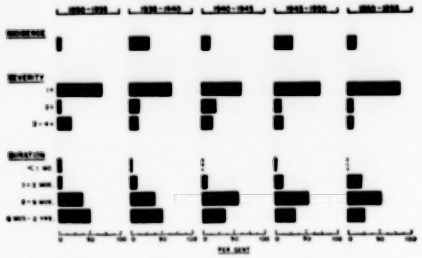


Fig. 1.—Comparison of incidence, severity, and duration of active carditis in 165 patient attacks (1930-1955).

trol group and hormone-treated groups before therapy reveals that those in the treated group were slightly more severe (see table).

The hormones used included corticotropin (ACTH), cortisone (compound E), and hydrocortisone (compound F). The average duration of therapy was seven days. The hormones were administered every six hours as follows: corticotropin intramuscularly, 25 units for four days and 20 units for three days, in total daily amounts of 80 to 100 units; cortisone orally, 100 mg. for four days and 80 mg. for three days, in total daily amounts of 320 to 400 mg.; hydrocortisone orally, 80 mg. for four days and 60 mg. for three days, in total daily amounts of 240 to 320 mg.

In our earlier studies it was found that during therapy the number of circulating eosinophils rose when the dosage was lessened or omitted.[5] After termination of therapy there was no clinical rebound in patients in whom the number of circulating eosinophils rose and

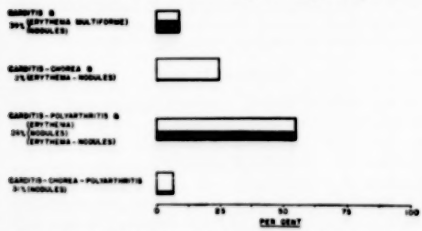


Fig. 2.—Severity of carditis related to associated manifestations. White square = 1+, or moderate severity; black square = 2-4+, or marked severity.

remained at normal levels. When the number of circulating eosinophils rose during therapy or failed to rise to normal levels after termination of therapy, a rebound could be predicted. Dosage was considered adequate when the count remained at zero levels during therapy. The various hormones used were equally effective. In the majority of patients, marked bradycardia was observed on the second day and transient hypertension occasionally noted at the end of therapy. No other untoward effects were observed. In all patients, within 24 to 72 hours after institution of therapy, the observed progressive symptoms and signs of active carditis were arrested and the associated manifestations regressed. By the third to seventh day, in the majority of patients, there was reversal of chamber enlargement to normal or previous size and new precordial murmurs regressed. Cardiac reserve was normal at the end of therapy.

After completion of therapy, most patients in whom therapy had been started in the third week developed transient fever or joint pains on the fourth to seventh day, and in three patients transient symptoms of carditis were observed, which regressed spontaneously. In six patients who had received inadequate therapy there was a recurrence of carditis within 24 to 72 hours, which was terminated by a second course lasting seven days. All

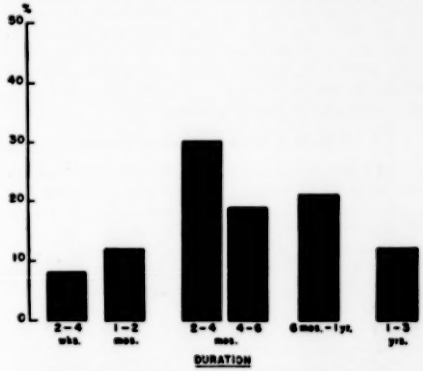


Fig. 3.—Duration of active carditis in 165 patient attacks.

patients were ambulatory within two to three weeks after the onset of therapy. A comparison of the duration of active carditis in the treated group revealed that, in two-thirds of the patients, active carditis lasted less than one month after onset of illness; in one-third of the patients it lasted less than two months. This is in marked contrast to the duration of active carditis in the control group where, in the majority, it was endured more than two months (fig. 4, *top*). In comparing the relationship between duration of active carditis and the time therapy is begun, it is found that the earlier therapy is started after onset, the shorter is the duration of active carditis (fig. 4, *bottom*). The onset was observed in one-half of the patients and estimated from history in the remainder. Two-thirds of the patients were treated within two weeks and one-third during the third week.

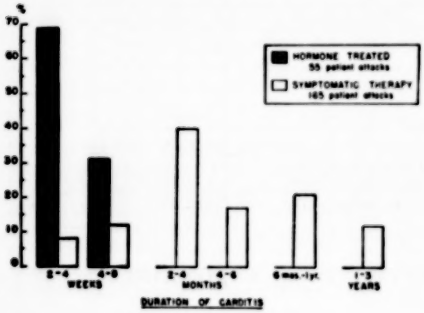
In comparing the extent of residual cardiac enlargement in treated and control patients, with presumably initial attacks, it was found that in 84% of the hormone-treated group there was no residual cardiac enlargement or valvular lesions (fig. 5). All of the patients in the control series had demonstrable enlargement of the heart and valvular lesions. In the majority of patients treated who had had a recurrent attack, no evidence of

increased cardiac damage after therapy was found. All of the patients in the control group demonstrated an increase in residual cardiac damage. It was also found that

Incidence of Symptoms and Signs of Active Carditis in 100 Control Patients and 55 Patients Treated with Hormones

	Control, %	Treated, %
Poor or distant heart sounds (tachycardia, gallop rhythm)	100	100
Friction rub	5	16
New and changing murmurs (systolic or diastolic)	68	70
Increasing enlargement of heart (on physical or fluoroscopic examination)	98	98
Diminishing cardiac reserve (fatigability, dyspnea, diminishing vital capacity)	98	98
Congestive failure (tender or enlarging liver, increased venous pressure)	45	50
Electrocardiographic abnormalities (increasing PR interval, ST changes)	20	50
Severity of carditis		
Moderate	70	71
Marked	30	29

during the follow-up period of six months to five years, murmurs regressed in two-thirds of the total group of treated patients as compared with one-third in the control series. It is significant that, as in the control group,



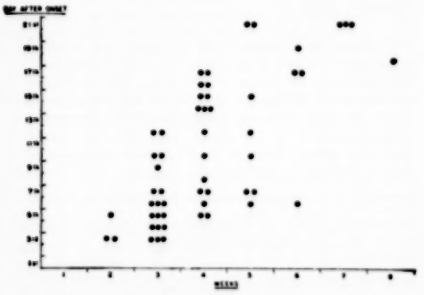


Fig. 4.—*Top*, duration of active carditis in patients receiving hormone and symptomatic therapy. *Bottom*, the day therapy is started after onset, related to duration of active carditis. Average treatment period = seven days.

there was no increase in cardiac size or appearance of new murmurs in the absence of a recurrent carditis during the follow-up period (fig. 5).

Comment

It is evident from these observations that the pattern of rheumatic carditis has not changed in the past 25 years. Of importance is the fact that increasing cardiac chamber enlargement or the appearance of new murmurs

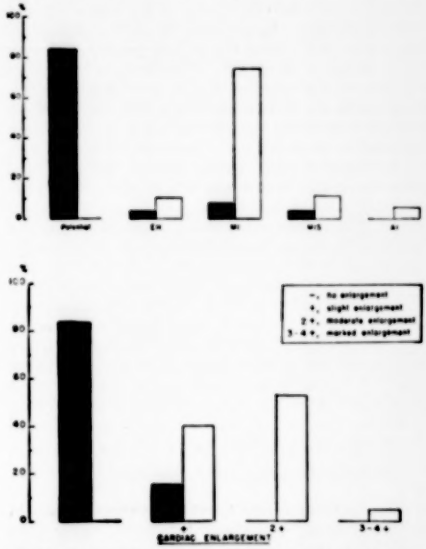


Fig. 5.—*Top*, comparison of anatomic diagnoses in hormone and symptomatic therapy (initial attacks). Black square = hormone-treated (follow-up period six months-5 years); white square = symptomatic therapy (follow-up period six months-20 years). Potential = predisposing history; EH = enlargement of heart; MI = mitral insufficiency; MIS = mitral insufficiency and stenosis; AI = aortic insufficiency. *Bottom*, comparison of residual cardiac enlargement in treated and control groups. Black square = hormone treated (25 initial attacks); white square = symptomatic therapy (72 initial attacks).

rarely occurred in the absence of an overt attack of active carditis. In view of these observations, evaluation of therapy would not seem to require several years of follow-up study. It would be most gratifying to be able to explain fully these dramatic results, but at the present time it is not possible to discuss the mechanism of hormone therapy in active rheumatic carditis. The nature of the chemical reactions involved in the rheumatic process is obscure. It is believed that hormones exert a nonspecific anti-inflammatory effect. There is also some evidence of a suppressive action on fibroblastic activity. The natural course of active carditis is self-limited. It is characterized by an acute or subacute inflammatory phase in which reversible and irreversible tissue changes occur. The extent and duration of the proliferative or healing phase depends on the degree of irreversible damage sustained, which in turn depends on the severity and duration of the rheumatic process.

Since we have demonstrated that in patients receiving hormone therapy the acute inflammatory phase is arrested within 24 to 72 hours, it is probable that further irreversible damage does not occur. During seven days

of therapy, the demonstrated reversal of chamber enlargement, the disappearance of murmurs, and the attainment of a normal cardiac reserve seemed to indicate that the damage sustained was reversible. The rheumatic process was apparently terminated with little or no residual cardiac damage. It is obvious that the later therapy is instituted, the greater is the chance for irreversible damage to be sustained. In eight additional patients who were treated one to four months after onset for a period of seven days, there was no reversal of chamber enlargement and no apparent influence on the duration of the disease. In a few who had an acute exacerbation during the chronic active stage, therapy appeared to arrest the acute symptoms. It is interesting to recall that another steroid, digitalis, has been used since Withering's time in the 18th century. We do not know, even today, the physiochemical basis for digitalis action. Evidence is accumulating that indicates that it acts on the contractile elements of the cardiac cell.[6] The possibility that hormone therapy may have an effect on the myocardium is suggested by our earlier observations of electrocardiographic changes, particularly increased amplitude of the T wave, in patients receiving hormone therapy.[5b] Similar electrocardiographic changes were observed in the intact dog after infusion of cortisone and related compounds.[7] Experimental investigations on the mechanism of hormone action on cardiac muscle, now under way, appear to offer support of an effect of these hormones at a cellular level.

Summary and Conclusions

Analysis of the course of active rheumatic carditis in patients receiving symptomatic therapy during the years 1930-1955 revealed no significant difference in the pattern of rheumatic fever over this 25-year period. The average duration of carditis was less than one month in only 20%, two to four months in 30%, and more than four months in 50%. Residual cardiac damage was present in every patient. In patients receiving hormone therapy 3-21 days after onset of illness, for an average period of 7 days, the duration of active carditis was less than one month in 69% and less than two months in 31%. In 84% of the patients treated, whose attacks were initial, there was no overt evidence of residual damage. The course of carditis in patients receiving hormone therapy is in marked contrast to that of the control group, both in duration and extent of residual cardiac damage. This is attributed to administration of adequate hormone therapy before irreversible damage was sustained.

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SUPERIORITY OF SURGICAL TREATMENT OF ENDOMETRIAL CARCINOMA

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• Endometrial carcinoma in six cases was treated by irradiation with x-rays and/or radium and later hysterectomy. In three of the cases the radiation was found not to have eradicated all the tumor cells. Since the delay between diagnosis and hysterectomy ranged from 9 to 17 weeks, the surviving tumor cells had ample time to multiply and metastasize before the uterus was actually removed.

Clinical evaluations and statistical analyses have failed to disclose the superiority of either primary hysterectomy or combined therapy for the treatment of endometrial carcinoma. It is most desirable that the superiority of one method be established so that all patients may be cared for in such a way as to provide the best possible opportunity for cure. The purposes of this comment are to formulate the principle of curative treatment, to critically explore the accomplishment of each therapeutic method, and to review the analysis of therapeutic results. These inquiries indicate that surgical treatment is superior to combined therapy and that the choice of method should be determined by the principle of treatment rather than by a comparison of survival rates.

Carcinoma of the endometrium arises in the epithelial cells lining the uterus and projects first into the cavity of the fundus. There is then slow and direct extension of tumor cells into the myometrium, with penetration of venous and lymph spaces in the thick muscle wall. From these vessels, tumor cells are swept in the vascular current to the parametrial structures, where metastases arise. It is possible that tumor cells may be carried from vessels of the myometrium directly to sites of distant metastasis. It is to be emphasized the penetration of the myometrium is a slow process and that extension to the serosa is a late event. It is unlikely that deep extension through the entire muscle wall occurs before tumor cells have spread beyond the uterus to sites of pelvic or distant metastasis. The gradual and direct spread of tumor cells through the myometrium is a characteristic growth

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pattern of carcinoma of the endometrium. In accordance with this growth pattern, the principle of treatment of endometrial carcinoma derives from four self-evident truths. These are: 1. Untreated endometrial carcinoma is continuously invasive, metastasis is inevitable, and the moment of metastasis is not predictable. 2. The extent of tumor cell penetration cannot be determined accurately before treatment is begun. 3. Delay in the eradication of cancer is attended by a period during which metastasis may take place. 4. The cure of cancer depends on the eradication of tumor cells. Therefore, the principle of treatment of endometrial carcinoma is the eradication of all tumor cells from the largest amount of pelvic tissue at the earliest possible moment after the diagnosis is established. The therapeutic method most closely complying with these objectives will necessarily provide the patient with the best possible opportunity for cure. However, delay in the onset of treatment, reduction in the amount of tissue cleared of tumor cells, or prolongation of the time required to complete treatment will necessarily lessen the opportunity for cure. Thus, the superior method of therapy may be disclosed by determination of the procedure that most nearly fulfills the objectives of the principle of treatment.

TABLE 1.—*Endometrial Carcinoma, St. Luke's Hospital, 1952-1954*

Case no.	1	2	3	4	5	6
Age, yr.	72	72	46	54	54	53
Patient delay,* wk.	12	2	4	7	5	16
Therapeutic delay,† wk.	17	9	14	15	12	11
External x-ray, r.	8,000	8,000	8,000	8,720	8,300	8,400
Radium, mg. hr.	None	None	6,000	6,000	5,800	4,700
Weights of uteri, gm.	222	165	110	118	82	83
Fibromyomas	Present	Present	None	None	Present	None
Endometrium	Present	Present	Present	Present	Present	None
Superficial tumor	Present	Present	None	None	None	Present
Deep tumor	Present	None	None	None	None	Present

* Period from onset of symptoms to diagnosis by curettage.
† Period from diagnostic curettage to hysterectomy.

TABLE 2.—*Residual Carcinoma of Endometrium After Intrauterine Radium Therapy*

Author	No. of Uteri	% of Patients with Residual Tumor
1. Taylor, H. C., Jr. and Becker, W. F.: Surg., Gynec. & Obst. 84: 129, 1947	119	49
2. Marshall [5]	93	74
3. Palmer and others [4]	86	69
4. Hundley and others [2]	67	71
5. Stowe [1]	53	50
6. Donovan, M. S., and Warren, S.: Surg., Gynec. & Obst. 75: 1,106, 1942	46	89
7. Scheffey, L. C., and others: Am. J. Obst. & Gynec. 52: 579, 1946	31	54
Total	495	62 (Av.*)

* Per cent figure converted to numbers of cases and sum divided by total cases.

In pursuance of this determination, it is first to be decided whether hysterectomy or radiation therapy clears the larger amount of pelvic tissue of tumor cells. If cases of endometrial carcinoma treated with radiant energy before operation reveal residual cancer in the removed specimens, it will be apparent that the operative procedure is superior to radiation therapy in the eradication of tumor cells. The record of tumor cell eradication with preoperative radiant energy in six cases of endometrial carcinoma treated during the past two years at St. Luke's Hospital is presented in table 1.

Table 1 discloses that morphologically viable epithelial cells were identified at the junction of endometrium with myometrium in all six cases. Malignant tumor cells were identified in the vascular spaces of the deep myometrium in two of six cases. It is apparent that preoperative radiation therapy did not eradicate all tumor cells from three of six cases. Figure 1 reveals the appearance of tumor cells lying within a vascular space in the deep myometrium of the patient in case 1. Investigations revealing the incidence of residual carcinoma in uteri after treatment with radiant energy are shown in table 2. It is apparent from table 2 that hysterectomy is superior to the effect of intrauterine radium in the eradication of tumor cells from pelvic tissues. The high incidence of residual carcinoma derives from penetration of tumor cells into the myometrium beyond the cancerocidal range of radium and from variations in cavitary contour that preclude intimate application of the radium to all of the tumor cells. Stowe [1] found distortions of the uterine cavities due to fibromyomas or to adenomyosis in 12 of 53 cases of endometrial carcinoma. Similar distortions due to fibromyomas were found by Hundley and associates [2] in 27 of 67 cases of endometrial carcinoma. Sampson [3] stated that variations in the situation of the carcinoma and the degree of its invasion often make the intimate application of radium to all of the growth a matter of chance or even impossible.

Fig. 1.—Tumor cells in vascular space of deep myometrium of patient in case 1.

When tumor cells are not identified in a removed uterus, it may be assumed that the carcinoma was superficial and that eradication of the cancer by radium was complete.

It is secondly to be decided whether primary hysterectomy or combined therapy provides an advantage in the saving of time for the completion of treatment. Hysterectomy is a procedure that may be performed without delay after the diagnosis is made; however, combined treatment ordinarily requires four to eight weeks for completion. During this time tumor cells beyond the range of radium, unmolested by the cancerocidal rays, continue to endanger the life of the patient, as there is no restraint to the development of distant metastatic disease. The significance of this short period may be negligible if the patient presents herself for treatment soon after the onset of symptoms and before myometrial invasion is extensive. However, for the patient who is not aware of the significance of her symptoms or who in fear procrastinates in the seeking of medical care and thus presents herself at a later period, the delay of definitive treatment may determine the difference between health and the inexorable ravages of widespread malignant disease. The adverse significance of this period of delay is increased by the fact that a small proportion

Fig. 2.—Carcinoma, *A*, limited to endometrium, *B*, with extension into deep myometrium, and *C*, beyond uterus and adnexa.

of these tumors are of high grade malignancy. Palmer and associates [4] found on review of histological grading of 786 carcinomas of the endometrium that 14.7% were highly anaplastic. In these cases, the moment of metastasis arrives early, and this is reflected in low survival rates regardless of the method of treatment. Therefore, in both economy of time and in amount of tissue cleared of tumor cells the operative procedure provides advantages over the radiation method in fulfilling the objectives of the principle of treatment.

Radium is also said to be useful in the control of infection and in the prevention of metastases due to operative manipulation of the uterus. The use of antibiotics to reduce infection within the uterus is not attended by risk to the patient. However, the insertion of radium to control infection necessitates delay of definitive treatment while a malignant lesion of unknown proportions continues to advance. Thus, the hazard of the method appears disproportionate to the end achieved even though successful. It is difficult to establish that radium prevents the spread of tumor cells due to operative manipulation of the uterus. The tumor cells most likely to metastasize are those lying within the vascular spaces of the deep myometrium at the peripheral margin of the advancing cancer. That the necrotizing effect of radium does not penetrate to such depths is indicated by Marshall,[5] who found viable tumor cells in all cases in which myometrial invasion had progressed beyond the inner third of the muscle wall. This occurred in 22 of 93 uteri; therefore, intrauterine radium, implanted centrally, is cancerocidal for those cells that are subsequently to be removed by hysterectomy and exerts relatively little or no effect on those cells from which metastases appear most likely to arise. Metastatic carcinoma in operative scars may be due to implantation of tumor cells from parametrial sites, because, in the performance of hysterectomy, incisions into the uterus are assiduously avoided and the parametrium is considerably beyond the cancerocidal range of intrauterine radium. The contention that intrauterine radium prevents metastasis due to operative manipulation of the uterus appears to be in want of evidence.

Contribution of Radium Preoperatively

Combined therapy is based on the premise that radium within the uterus before operation provides an advantage over hysterectomy alone in the eradication of tumor cells. This premise is an assumption that may be explored by reference to figure 2. Cases amenable to cure are essentially those in which all tumor cells are within the uterus (*A* and *B*). When the cancer is superficial (*A*), both radium and hysterectomy are curative and there is equality of therapeutic accomplishment; however, when the cancer is deep (*B*), and some tumor cells are spread beyond the cancerocidal range of radium, only hysterectomy is curative. Therefore, intrauterine radium provides no contribution to hysterectomy in the eradication of tumor cells, and for this reason combined therapy cannot be superior to the primary surgical treatment of endometrial carcinoma. When the carcinoma is superficial, radium may be curative. In this event, the subsequent hysterectomy provides no contribution to the result and needlessly exposes the patient to the risk of a major operation. When the cancer is deep, the preoperative application of radium is redundant, because cure cannot be achieved without hysterectomy. In this event, delay in the removal of cancer is countenanced and the patient is needlessly exposed to the possibility of radium-induced complications. Therefore, in both events, combined therapy necessitates disadvantages that are not incurred with primary surgical treatment. Since depth of tumor cell penetration may render the effect of intrauterine radium inferior to that of hysterectomy, and as that depth cannot be defined at the onset of treatment, and as hysterectomy is obligatory regardless of that penetration, the reason for inserting radium into the uterus before operation is obscure.

Evaluation of Treatment

Combined therapy necessitates two digressions from the principle of curative treatment. The first is the use of an agent that clears tumor cells from less tissue than can be accomplished by hysterectomy and the second is delay in the performance of hysterectomy. Since there is no reason to believe that therapeutic success can be improved by delaying the eradication of tumor cells or by reducing the amount of tissue cleared of tumor cells, it is possible that reports indicating superiority of com-

bined treatment may be misinterpreted. Therefore, it is in order that the method of evaluating therapeutic results be explored. The gauge of therapeutic accomplishment is the survival rate, which is determined by the method of treatment and by the conditions under which treatment is applied. These conditions are the variables of the analysis. It is proposed that compilation of a large number of cases will equate the variables and that the superiority of one method will then be revealed by a comparison of the survival rates after each method of treatment. However, this comparison can be successful only if the difference in the accomplishment of the two methods is a factor of significance in relation to the effect of the variables on the rates of survival; otherwise, it will not be possible to determine whether a favorable survival rate is due to the variables of the analysis or to the contribution of the method of treatment. This is in accordance with the axiom that a statistical result is no more accurate than the least accurate of the factors that make up the computation. Therefore, an estimate of the effect of the variables on the rate of survival may be compared with the effect of the difference in the accomplishment of the two methods of treatment.

TABLE 3.—*Range of Results of Combined Treatment*

Author	No. of Cases	5 Yr. Survival Rate, %
1. Hall, J. E., and others: Am. J. Obst. & Gynec. **59**: 634, 1950	17	94.1
2. Payne, F. L.: Surg., Gynec. & Obst. **94**: 715, 1952	28	92.9
3. Marshall [5]	48	88.0
4. Hundley and others [2]	32	84.4
5. Corscaden, J. A., and Tovell, H. M. M.: Am. J. Obst. & Gynec. **68**: 737, 1954	105	82.8
6. Corscaden, J. A.: J. A. M. A. **128**: 1134 (Dec. 30) 1954	25	72.0
7. Arneson, A. N.: Bull. New York Acad. Med. **29**: 295, 1953	60	70.0
8. Masson, J. D.: New Orleans M. & S. J. **92**: 235, 1939	191	67.5
9. Ward, G. G.: Am. J. Obst. & Gynec. **44**: 303, 1942	37	64.9
10. Taylor, H. C., Jr., and Becker, W. F.: Surg., Gynec. & Obst. **84**: 129, 1947	31	64.5
11. Speert, H., and Peightal, T. C.: Am. J. Obst. & Gynec. **56**: 502, 1948	28	63.4
12. Waterman, G. W., and others: Am. J. Obst. & Gynec. **64**: 1073, 1952	67	61.2
13. Scheffey, L. C., and others: Am. J. Obst. & Gynec. **52**: 529, 1946	37	46.0

The distribution of tumor cells at the time of treatment is the most important variable of the analysis; for example, if a high proportion of superficial tumors is present in one group of cases, the result of treatment will be favorable, because all tumor cells will be removed. If, however, a high proportion of deeply spread cancers happens to be present in a clinically similar group of cases, the therapeutic results will be unfavorable, because in many, tumor cells will have spread beyond the margins of resectable pelvic tissue. It is not possible to accurately determine by physical examination of the patient at the onset of treatment whether tumor cells have reached the deep myometrium, the parametrium, or the pelvic lymph nodes. Therefore, the variable of tumor cell distribution is the major determinant of survival rate. An exceedingly large number of cases is required to equate a variable of this magnitude.

In addition to the factor of tumor cell distribution, there are several lesser variables that also affect the rate of survival. Two clinically comparable series of cases may be rendered dissimilar by differences in the scope of the surgical excision, by variations in the dose or methods of application of radiant energy, by differences in the pathological interpretation of equivocal lesions, by variations in the proportion of tumors that may be resistant to radiant energy, or by differences in the incidence of anaplastic tumors in either group of cases. Therefore, the survival rate after each method of treatment is subject to the cumulative effect of several unavoidable variables, and, for this reason, separate series of cases treated by the same method may be expected to reveal a wide range of results. Tables 3 and 4 reveal the distribution of results after each method of treatment.

The difference in the maximum possible accomplishment that can be found between the two methods of treatment may now be defined. Treatment with radium alone may be expected to cure only those patients in which all tumor cells lie within the cancerocidal range of that agent. Combined treatment is superior to radium therapy by the proportion of cases in which tumor cells lie beyond the cancerocidal range of radium yet within the boundaries of resectable pelvic tissues. Primary surgical treatment is superior to combined therapy by the proportion of cases in which extrauterine metastasis takes place during the delay of operation used for the application of radium. The frequency of metastasis during this period, which varies with the rate of growth of the tumor, with the length of the delay, and with the depth of penetration of tumor cells at the time treatment is begun, cannot be determined until it is possible to follow the movement of tumor cells within the body.

TABLE 4.—*Range of Results of Primary Hysterectomy*

Author	No. of Cases	5 Yr. Survival Rate, %
1. Marshall [5]	31	80.0
2. Payne, F. L.: Surg., Gynec. & Obst. **94**: 715, 1952	46	80.4
3. Hall, J. E., and others: Am. J. Obst. & Gynec. **59**: 634, 1950	9	77.7
4. Waterman, G. W., and others: Am. J. Obst. & Gynec. **64**: 1073, 1952	22	68.2
5. Arneson, N. A.: Bull. New York Acad. Med. **29**: 295, 1953	43	67.7
6. Masson, J. D.: New Orleans M. & S. J. **92**: 235, 1939	250	66.6
7. Corscaden, J. A., and Tovell, H. M. M.: Am. J. Obst. & Gynec. **68**: 737, 1954	51	66.6
8. Taylor, H. C., Jr., and Becker, W. F.: Surg., Gynec. & Obst. **84**: 129, 1947	17	64.7
9. Ward, G. G.: Am. J. Obst. & Gynec. **44**: 303, 1942	27	63.0
10. Speert, H., and Peightal, T. C.: Am. J. Obst. & Gynec. **56**: 502, 1948	95	48.4
11. Scheffey, L. C., and others: Am. J. Obst. & Gynec. **52**: 529, 1946	12	41.6

However, there is no evidence to suggest that metastasis during this period is frequent. Indeed, the characteristically slow rate of growth of endometrial carcinoma, the gradual invasion of the thick muscle wall, and the increasing proportion of patients who request diagnosis soon after the onset of symptoms, suggest that tumor cell spread beyond the uterus during this short interval is most infrequent. Therefore, evidence is wanting to indi-

cate that the difference in the accomplishment of the two methods has more than a negligible effect on the rate of survival.

The effect of the unavoidable variables on the rate of survival is undeniably great, and the effect of the difference in the accomplishment of the two therapeutic methods on the rate of survival is by comparison slight. Therefore, the difference in the accomplishment of the two methods of treatment cannot be detected until the variables are equated or eliminated. There is no forseeable way to accomplish the latter, and the number of cases available for analysis is not sufficient to equate the variables. There is no justification for attributing a favorable survival rate to the method of treatment in disregard of the variables. Therefore, evaluation of treatment by comparison of survival rates cannot be expected to reveal the superiority of either method. In this area in which superiority of method eludes statistical demonstration, guidance for therapy may be found in the commanding logic of the principle of treatment. The objective of therapy is the eradication of malignant tumor cells. It may be asserted that the procedure known to clear all tumor cells from the largest amount of pelvic tissue with the least delay will be followed by the highest possible rate of survival. Therefore, undelayed hysterectomy, limited in extent by the technical skill of the surgeon and by the ability of the patient to withstand the procedure safely, brings harmony between the principle and the method of treatment and represents the superior form of therapy of endometrial carcinoma. This superiority will prevail until a nonsurgical method is developed that clears all tumor from more tissue with less delay than is provided by primary hysterectomy. When the interval from the onset of malignancy to the diagnosis of cancer is short, and when the superior method of treatment is uniformly applied without delay, the maximum survival rate will be achieved until new developments outmode current practice.

Summary

The principle of treatment of endometrial carcinoma is the eradication of all tumor cells from the largest amount of pelvic tissue with the least possible delay after the diagnosis is established. Combined treatment digresses from this principle by use of an agent that clears tumor from less tissue than can be accomplished by hysterectomy and by delay in the performance of hysterectomy. Primary surgical treatment is superior to combined therapy by the proportion of cases in which extrauterine metastasis occurs during the period of delay that precedes operative removal of the uterus. The difference in the accomplishment of the two methods is slight, the variables of the analysis dominate the survival rate, and the number of cases available for evaluation is inadequate to equate the variables. Therefore, comparison of survival rates cannot be expected to disclose the superiority of primary surgical treatment. The procedure that most nearly fulfills the objectives of the principle of treatment will provide the best possible opportunity for cure. It is, therefore, recommended that the method of therapy be selected according to the principle of treatment, rather than by a comparison of survival rates.

705 Cooper St.

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CLINICAL NOTES

PREOPERATIVE DIAGNOSIS OF SEQUESTRATION OF THE LUNG BY AORTOGRAPHY

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and
William R. Eyler, M.D., Detroit

The diagnosis of pulmonary sequestration is always tentative until an exploratory thoracotomy confirms the preoperative impression. The following case report illustrates the value of aortography in establishing this diagnosis prior to surgical intervention.

Report of a Case

A 42-year-old woman complained of a backache of three months' duration. The pain was localized to the lower thoracic spine and radiated to both right and left costal margins. It was aggravated by movements of the trunk and was especially severe during the night and early morning. Her family physician hospitalized her and, after studies, treated her for a gastric ulcer. This therapy failed to alleviate her symptoms, and she came to the Henry Ford Hospital clinic.

The initial physical examination, urinalysis, routine blood studies, and serologic tests for syphilis were all normal. The routine photofluorogram demonstrated a soft tissue density (fig. 1) in the left lower chest adjacent to the spine. The patient was then admitted to the hospital for further investigation. Fluoroscopy and films of the chest again showed the mass adjacent to the 9th to 12th thoracic vertebral bodies and the aorta, tapering into the medial posterior angle of the left chest inferiorly. Pulsations were not observed fluoroscopically. The right upper lung field showed a few old fibrocalcific scars from previous infection. Films showed no abnormality of the spine or thoracic cage. An upper gastrointestinal examination showed no evidence of deformity of the esophagus and no abnormality in the stomach or duodenum.

A photofluorogram of the chest made in 1942 was then obtained, and it showed the mass present at that time. This seemed to rule out a malignant process, and the differential diagnosis was thought to lie between aneurysm of the aorta, a benign mediastinal or pulmonary tumor, and a sequestration of the lung; an aortogram was made to distinguish between aneurysm and sequestration. We also considered it important to determine the relation of the celiac artery to the paravertebral density in the event the lesion was an aortic aneurysm. The aortic puncture was made at the level of the 12th thoracic segment, with the

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bevel of the needle directed upward. During the injection of 30 cc. of 70% sodium acetrizoate (Urokon), the femoral arteries were occluded by pneumatic tourniquets. The aortogram demonstrated an anomalous vessel arising between the 9th and 10th intercostal arteries on the left and entering the paravertebral soft tissue density (fig. 2).

The diagnosis of sequestration of the lung was thus established. Thoracotomy was performed on Feb. 16, 1955, through an incision in the left seventh intercostal space. The mass was

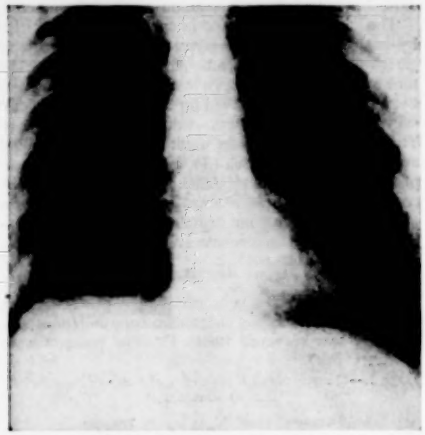

Fig. 1.—Admission photofluorogram. The sequestration is seen in the lower left medial angle of the chest.

located in the posterior basal segment of the lung adjacent to the aorta. It was not aerated and was cystic in consistency. The anomalous vessel measured 4 mm. in diameter and arose from a small button-like elevation of the lateral wall of the aorta. It pulsated only slightly; on division, the lumen was found to

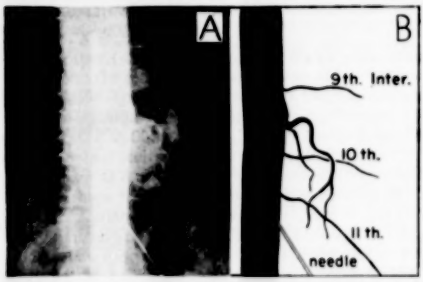

Fig. 2.—*A*, aortogram, showing large anomalous vessel on the left side between two smaller 9th and 10th intercostal arteries. It enters into and ramifies within the soft tissue density. *B*, diagram depicting normal and anomalous vessels.

be about three-fourths occluded by arteriosclerosis. A large nerve trunk from the greater splanchnic nerve accompanied the vessel into the sequestraied lung. As usual, the venous drainage was to the pulmonary veins. The patient's postoperative course was uncomplicated, and she was discharged from the hospital on the 12th postoperative day. She has been free of back pain since the operation.

Pathological examination of the specimen showed a mass of tissue that weighed 25 gm. It was semisolid in consistency, and in one portion was an elongated cystic cavity measuring 2 by 3 cm. containing gelatinous tan-colored material. On microscopic examination, the classic features of a sequestration were noted. The main arterial vessel entering the mass was markedly narrowed by arteriosclerosis.

Pryce [1] presented a good review of the subject of sequestration of the lung in 1946. Bruwer, Clagett, and McDonald [2] presented 10 cases and reviewed the subject in 1950 [2a] and 1954,[2b] particularly from the radiological aspect. They record backache as a leading complaint in two of their patients. Wyman and Eyler [3] described the roentgen appearance; this case fits the criteria suggested by them. An editorial in THE JOURNAL of June 26, 1954,[4] reviewed the subject briefly.

Summary

In a case of sequestration of the lung, retrograde aortography established an exact preoperative diagnosis by demonstration of the anomalous artery from the aorta, branching in the sequestrated lung. It is suggested that a retrograde aortogram be made when this diagnosis is considered.

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TOPICAL ANESTHESIA WITH HEXYLCAINE (CYCLAINE) FOR MAJOR ENDOSCOPIC PROCEDURES

EVALUATION AND COMPARISON IN 1,732 ADMINISTRATIONS

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and
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Endoscopic procedures in which topical anesthesia is used are fraught with the danger of toxic reactions from the local anesthetic drug employed. Previous reports [1] have shown that with drugs such as cocaine and tetracaine (Pontocaine) there is inherent danger of convulsions, respiratory and/or circulatory failure, and death. Only the rigid observance of rules limiting total dosage and specific techniques prevent more frequent occurrence of these untoward reactions. These reactions occur with the most skilled operators and can be eliminated or minimized only if an efficient, less toxic drug is available. These considerations prompted this survey. A preliminary report [2] of 100 cystoscopic and 238 bronchoscopic

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The directors and staff of the Thoracic Surgical Service, Bellevue Hospital, assisted in this survey.

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examinations without untoward reactions justified the utilization of hexylcaine (Cyclaine) during the past four years in the bronchoscopic clinic of the thoracic surgical service at Bellevue Medical Center.

Methods

No control study was attempted other than a comparison with the previous year, when 1% tetracaine with or without 10% cocaine was used. Starting in 1950, 5% hexylcaine was substituted for all available topical anesthetic agents and used in every topical anesthetic procedure except on occasion when the supply was exhausted. Topical anesthesia was administered by the assistant residents of the thoracic surgical service. No limit was placed on the amount of drug used. Patients were from the medical and surgical services of Bellevue Hospital. The majority were suspected of having or having had pulmonary tuberculosis or carcinoma of the lung.

Preoperative medication consisted of 50 to 100 mg. of meperidine (Dermerol) and 0.3 to 0.4 mg. of atropine or scopolamine by the subcutaneous route given approximately one-half to one hour prior to the start of the anesthetic administration. The mouth and pharynx were sprayed with a DeVilbiss nebulizer no. 40. Swabs dampened with 5% hexylcaine were placed in the pyriform fossae for one minute. Two milliliters of the solution was injected into the trachea with the aid of indirect laryngoscopy. The patient was tilted from side to side to insure anesthesia of the main-stem bronchi. Not infrequently, this procedure was repeated when there were indications that the solution had flowed mainly into one side. The patients were advised not to swallow any solution. The procedure outlined above consumed approximately 10 minutes, and anesthesia was present within 1 to 2 minutes after the solution reached the mucosa.

The amount of drug used in each case was recorded by subtracting the amount remaining in the medicine glass from the measured amount at the beginning. The time from onset of anesthesia to completion of the operative procedure was recorded for 500 patients. The efficacy of the anesthesia was evaluated by the operator. The following criteria were used: (1) good—procedure accomplished with ease, (2) fair—procedure accomplished but with some difficulty, either mechanical, coughing, or the anesthesia not completely satisfactory; (3) poor—procedure not completed because of mechanical difficulties or inadequate anesthesia.

TABLE 1.—*Total Major Endoscopic Procedures During a Five-Year Period (1950-1954) Classified as to Year and Type of Procedure**

	Bronchoscopy		Esophagoscopy and Bronchoscopy		Esophagoscopy	
Yr.	No. of Patients	No. of Procedures	No. of Patients	No. of Procedures	No. of Patients	No. of Procedures
1950	304	371	8	8	10	14
1951	316	353	4	4	20	25
1952	303	328	19	19	10	11
1953	256	281	4	4	19	21
1954	235	243	3	3	21	38
Total	1,414	1,576	38	38	80	109

* Total patients 1,532; total procedures 1,723.

TABLE 2.—*Major Anesthetic Agents Utilized in the Series and the Results**

		Results					
		Good		Fair		Poor	
Drug and Yr.	No.	No.	%	No.	%	No.	%
5% hexylcaine							
1951	380	350	92	22	5.8	8	2.2
1952	341	306	90	23	6.5	12	3.5
1953	274	260	95	10	3.5	4	1.5
1954	267	251	94	9	3.4	7	2.6
Total	1,262	1,167	92.5	64	5	31	2.5
1%-2% tetracaine †							
1950	388	345	..	30	...	13	...
1952	8	7	..	0	...	1	...
1953	24	21	..	1	...	2	...
1954	16	14	..	2	...	0	...
Total	436	387	89	33	7.5	16	3.5

* No hexylcaine was used prior to 1951 and no tetracaine was used in 1951.

† Some of the patients in this group received 10% cocaine added to the tetracaine solution.

Results

A total of 1,723 major endoscopic procedures on 1,532 patients consisting of bronchoscopy and/or esophagoscopy was surveyed (table 1). The patients were adult men (80%) and women (20%), with an age range from 14 to 80 years. Two modes were noted, one between 20 and 40 years and the other between 50 and 65 years of age. Anesthesia was accomplished with 8 ± standard deviation (S.D.) 2.5 ml. (400 ± S.D. 125 mg.) of 5% hexylcaine. The anesthesia time (onset of anesthesia to end of endoscopy) was 8.5 ± S.D. 6.5 minutes.

Hexylcaine was the anesthetic agent used in 1,262 (73%) of the procedures. Of these, only 2.5% were graded as poor. This result compares very favorably with the results when 1%-2% tetracaine with and without 10% cocaine was used in 436 (25%) of the cases analyzed (table 2). The remaining 25 (2%) of the endoscopies were performed with lidocaine or general anesthesia. These are two few to offer any useful information. Results were evaluated as fair in 64 (5%) and poor in 31 (2.5%) of the 1,262 procedures performed with hexylcaine anesthesia. Anesthesia was implicated in 37 (2.9%) and 14 (1.1%) of these results respectively. The results in the other procedures, judged less than good, were considered unsatisfactory because of mechanical difficulty associated with anatomic distortions of the patients. The reasons for inadequate depth of anesthesia are listed in table 3. Excessive secretions

TABLE 3.—*Comparison of the Number of Fair and Poor Results Due to Anesthesia**

Hexylcaine		Tetracaine	
Fair	37 attempts (2.9%)	Fair	11 attempts (2.5%)
Inadequate anesthesia	12	Inadequate anesthesia	11
Secretions	14		
Cough	11		
Poor	14 attempts (1.1%)	Poor	10 attempts (2.1%)
Inadequate anesthesia	9	Inadequate anesthesia	8
Secretions	2	Reaction	2
Uncooperative	2		
Reaction	1		

* No statistical significance is noted between 5% hexylcaine and 1%-2% tetracaine with or without 10% cocaine.

were noted not only to offer a problem per se but also to prevent the production of an adequate depth of anesthesia. A comparison of the unsatisfactory results with hexylcaine to those with 1%-2% tetracaine with and without cocaine indicate that hexylcaine may actually have a slight advantage in the production of adequate anesthesia.

Reactions

Three reactions occurred during the course of this survey, two with tetracaine (0.45%) and one with hexylcaine (0.08%). Both patients who had reactions with tetracaine had had repeated convulsions. They were treated with barbiturates intravenously and oxygen. The results of this therapy were excellent, and both patients survived. Since reactions due to tetracaine have been adequately described in the literature,[3] only the one reaction with hexylcaine will be described in detail.

A 32-year-old woman, who was well-nourished and well-developed, was admitted for diagnosis and therapy of pulmonary tuberculosis. Her medical history offered little positive information. Fourteen years previously the patient had teeth extracted with procaine anesthesia, and three years later a tonsillectomy was performed with ether anesthesia. There were no untoward reactions to anesthesia either time. In 1943, the patient was delivered of a son while under ether anesthesia. After this, paralysis of the left side of the face lasted one month. In 1945, following delivery of a daughter while under ether anesthesia, patient had paralysis of the right lower extremity. Bed rest for three months and crutches for two weeks were necessary.

For bronchoscopy the patient received 75 mg. of meperidine and 0.4 mg. of scopolamine 45 minutes prior to receiving topical anesthesia. Though she appeared extremely apprehensive, she felt listless and lifeless. A total of 9 cc. of 5% hexylcaine (450 mg.) was used as already described. Before the bronchoscope was introduced, while the procedure was being explained to the patient, she suddenly had a clonic convulsion. Cyanosis was marked. A mouth gag was introduced and oxygen administered. The convulsion, lasting 40 seconds, was completed before drug therapy could be administered. No change in blood pressure or pulse followed the convulsion. Unconsciousness preceded gradually to preoperative alertness in seven minutes. Bronchoscopy was not performed. Recovery was uneventful. The next day the patient could recall only the events until she was moved to the bronchoscopy table. Skin tests to procaine, hexylcaine, and saline solution were negative.

Comment

Objective evaluation of the safety of topical anesthetic agents for major endoscopic procedures presents considerable difficulties. Hexylcaine, while possessing noteworthy safety, is not without the possibility of causing untoward reactions. The difference between the number of reactions with tetracaine or hexylcaine was not significant in this survey. However, when hexylcaine is compared to tetracaine in the survey of 1,000 cases published by Weisel and Tella,[3] the reduction in the number of major reactions is significant at the 5% level and the number of total reactions at less than 1% level. The efficacy of hexylcaine is evident. The percentage of good results (92.5%) obtained with this agent exceeded, but not with statistical significance, the percentage of good results (89%) with tetracaine. The prime difficulty attributable to both anesthetic agents was lack of adequate anesthesia associated with excessive secretions. Preliminary medication with scopolamine or atropine and proper attention to the reduction of secretions by medical and surgical therapy will reduce the percentage of failures. General anesthesia was rarely necessary in this clinic. It was employed in only 1% (22) of the procedures in this series.

Summary

A survey of topical anesthesia employed in 1,723 procedures (1,262 with 5% hexylcaine and 436 with tetracaine) suggests that 5% hexylcaine is a safer and more satisfactory drug than tetracaine. Good anesthesia was obtained in over 92.5% of the procedures performed during hexylcaine anesthesia. One toxic reaction occurred.

550 First Ave. (16) (Dr. Rovenstine).

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INTERSTITIAL PNEUMONITIS IN DERMATOMYOSITIS

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and
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Although clinical involvement of the lungs has been described frequently in collagen tissue diseases such as diffuse scleroderma, disseminated lupus erythematosus, and periarteritis nodosa, it has not been reported as a cause of the presenting symptoms in dermatomyositis or indeed a prominent feature of the disease at any time. So far as can be ascertained from recent literature, the following case is unique in this respect.

The patient had dermatomyositis with symptoms referable to the respiratory tract that remained the outstanding feature of the illness throughout its entire course. The case would seem to forge another link in the chain that binds collagen tissue diseases together, although it fails to shed further light upon the etiological background of this interesting group.

Report of a Case

A 52-year-old woman was admitted to the Montreal General Hospital on Jan. 2 and died Feb. 11, 1953. She had been referred here because of an almost continuous brassy, nonproductive cough precipitated by exertion, together with moderately severe dyspnea. These symptoms had been present for three months. During this time she noticed some swelling of her hands, with loss of sensation during the night.

The patient was born in Harrowgate, England, but lived in Bermuda for nine years working as a ledger clerk in a bank. There was a brief history of allergy, in that she had experienced a severe urticarious reaction requiring administration of epinephrine after receiving diphtheria antitoxin in 1939. In October, 1942, she had had an attack of hives lasting two days and clearing up spontaneously. The only other episode in her history was one of back pain in the lumbar area, thought to be due to a herniation of the nucleus pulposa, for which she had been hospi-

From the Montreal General Hospital.

talized in March, 1952. She described the onset of her last illness as follows: In mid-September, 1952, she had a relatively sudden onset of coughing. At first the cough came in paroxysms lasting 10 to 15 minutes, generally terminated by vomiting. For three months the cough had been almost constant on the slightest exertion, such as turning in bed. It was dry, nonproductive, and not associated with hemoptysis. There was no chest pain at any time. With the onset of the cough, she noticed increasing shortness of breath, even when walking on the level.

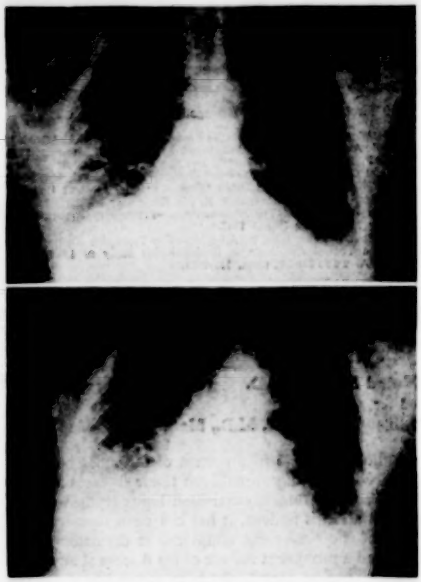

Fig. 1.—Roentgenograms of chest, showing widespread interstitial infiltration within parenchyma of right lung and to lesser extent in left lower lobe, made on (*A*) Jan. 2 and (*B*) Jan. 14, 1953.

For six weeks she had noticed some swelling and aching of the hands. In addition to this symptom, she noticed blanching in the fingers and hands when grasping an object such as a knife or fork. The blanching, as a rule, lasted 10 to 15 minutes and cleared up with massage, but the hands were blue for some time after the attack. At no time was there blanching of the fingers when the hands were placed in cold water. During this period of six weeks, she also noticed a change in the contour of her face and particularly swelling and blueness of the cheeks, but no definite skin lesion was present either on the face or elsewhere. Weight loss was 15 lb. (6.8 kg.) in four months.

Physical Examination and Laboratory Data.—At the time of admission little was to be found on physical examination. The patient appeared flushed and febrile, but no abnormalities were noted upon examination of the heart, lungs, and abdomen. Blood pressure was 118/74 mm. Hg. A few inspiratory moist, crepitant rales were noticed at the base of both lungs, but these were not considered to be significant, as they were not accompanied by other abnormal physical signs.

The striking features on examination were confined to the skin and muscles, with some swelling of the small joints of the hands suggestive of mild rheumatoid arthritis. There was, however, no ulnar deviation as commonly seen in that disease. The skin over the fingers was shiny, atrophic, and fixed to the subcutaneous tissues as seen in scleroderma. The muscles of the extremities were painful to pressure and movement. No dysphagia was present, nor was there facial pigmentation or eruption.

The urinalysis revealed a high to normal specific gravity, 0 to 30 mg. of albumin per liter, no sugar, and no abnormal sediment. On the day of admission the hemoglobin level was 14.3 gm. per 100 cc., erythrocytes 4,800,000 per cubic millimeter, leukocytes 7,700 per cubic millimeter, platelets 210,000 per cubic millimeter, reticulocytes less than 1%, mean corpuscular volume 95 cubic microns, sedimentation rate 1.1 mm. per minute (0.38), and a differential cell count of polymorphonuclear cells 65%, lymphocytes 21%, and eosinophils 14%. The only abnormality revealed by electrocardiogram was a left axis deviation. A heavy growth of normal flora was found in the sputum test. Serum creatinine was 1.3 mg. per 100 cc. (range, 0.90-1.65), and serum creatine was 1.5 mg. per 100 cc. (0.35-0.93). In 24 hours' excretion of urine the creatinine was 1.3 gm. per 100 cc. (1.0-1.5) and the creatine 0.37 gm. Roentgenograms of the chest showed evidence of widespread interstitial infiltration within the parenchyma of the right lung and to a lesser extent in the left lower lobe. The roentgenograms, which were made on Jan. 2 and again on Jan. 14, are reproduced in figure 1.

Hospital Course.—The patient ran a low-grade fever from Jan. 2 to Jan. 17. Then for five days the temperature rose to 103 F (39.4 C), after which there was only an occasional spike every third or fourth day. The striking feature of the illness was the cough, which was brought on by the slightest movement of the patient, such as being rolled over in bed. To this was added severe pain in the muscles when she was moved. These paroxysms lasted some minutes, during which she was in agony. Antihistaminics had no effect, but codeine gave considerable relief. Death occurred on Feb. 11. The blood pressure remained low-normal throughout the illness. Little change was noted in the muscle tenderness or puffiness of the skin.

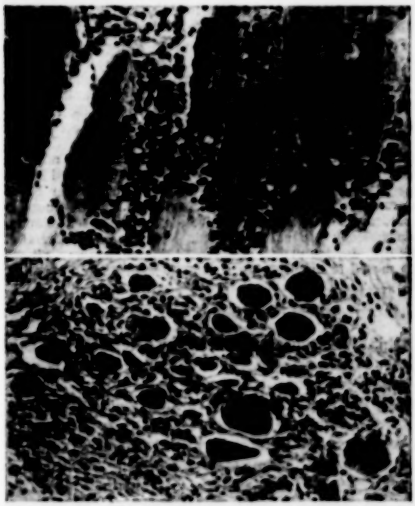

Fig. 2.—*A*, triceps muscle in antemortem biopsy (× 100), illustrating the nonsuppurative, inflammatory exudative reaction separating individual muscle fibers. *B*, psoas muscle from postmortem examination (× 100), showing the marked progression of the process, with destruction and atrophy of the muscle fibers and wide separation of their degenerated remnants by a fibroproliferative, chronic inflammatory reaction.

Treatment.—On Jan. 5 a biopsy was made of muscle and skin of the deltoid area, but no skin disease was identified by the pathologist. Examination of the muscle revealed nonsuppurative interstitial myositis. Several days later a skin biopsy of the forearm disclosed the presence of mild perivascular dermatitis and nonsuppurative panniculitis (figure 2*A*). On Jan. 9 she was given corticotropin (ACTH), 25 units twice daily; there was an im-

mediate drop in circulating eosinophils that, however, was not sustained. She appeared to be somewhat improved and to have less muscle pain. On Jan. 28 corticotropin therapy was discontinued and cortisone, 150 mg. daily, was substituted. A rise in temperature, chills, and an increase in muscle pains forced the substitution of corticotropin, on Jan. 30, 75 units twice daily. At this time the leukocyte count was 20,800 per cubic millimeter and the circulating eosinophils 9,500 per cubic millimeter. Despite a satisfactory drop resulting from the hormone therapy, deterioration was progressive until the patient's death on Feb. 11.

Autopsy.—At autopsy there was some excess fluid in each pleural cavity. There were no pleural adhesions. The right lung weighed 360 gm., and the left lung weighed 350 gm. Lungs were firm and normally crepitant, with more than usual resistance on palpation. No purulent material was expressed from the cut surface. The other organs were normal in appearance. On microscopic examination, striking changes were noted throughout the muscles and the skin (fig. 2*B*). The changes were similar in all muscles, including the heart and diaphragm. The pathologist's

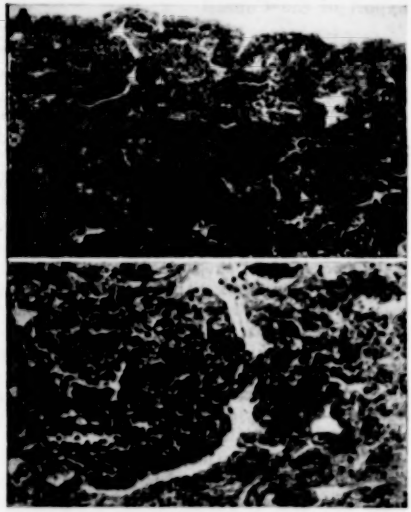

Fig. 3.—*A*, lung tissue (× 40), with a wide area, extending to the pleural surface, in which all alveolar structure is obliterated in a productive fibrosis with nonspecific inflammatory cell infiltration. *B*, lung tissue (× 100), with greater detail of the pulmonary fibrosis and chronic inflammatory cell infiltrate.

description of a section from a pectoral muscle is as follows: The muscle is arranged in its usual bundles but shows a profound, multifocal, exudative, and destructive myositis, there being many smaller and larger foci within muscle bundles where the fibers are separated and destroyed in a profound inflammatory reaction consisting of lymphocytes with a few plasma cells and some polymorphonuclear leukocytes, and within which areas there are remnants of disintegrating and fragmented muscle fibers in varying stages of degeneration. Sometimes these exhibit some sarcolemmic nuclear proliferation. In the inflammatory foci there are frequent multinucleated giant cells not containing foreign bodies but tending more to be a foreign-body type. Some of these merge distinctly into swollen or fragmented muscle fibers and can be derived from these structures, though this is not always so evident. In the uninvolved areas the muscle fibers are arranged in the usual bundles, and, while they show some variation in size and in staining and a few scattered fibers are hyaline in appearance, there is no diffuse muscle atrophy. The intermuscular septums generally are not remarkable, although at one or two points small inflammatory collars are seen about the small blood vessels. There is no arteritis or other vascular lesion in evidence. The lesion is unlike that seen in trichinosis, and no parasitic elements are recognized. Scattered small nerve trunks throughout the muscle appear to be intact.

The skin lesion was described as follows: The section of skin from the sternum area consists of a long strip with underlying subcutaneous fat, the latter tissue being intact and free of vascular or other lesions. The skin is not particularly striking but does show some abnormality. There is a mild, scaling hyperkeratosis, though the stratum granulosum is relatively thin and not prominent. The epidermis, generally, is thin and somewhat atrophic and in a number of areas has lost its rete pegs. In scattered foci there is intracellular edema in the Malpighian layer, with balloon cell formation. There is some apparent hyperpigmentation in the basal layers of the epidermis. Beneath this, involving the subpapillary layer of the corium, there is pronounced edema of the collagen, with some degenerative swelling and homogenization of collagen. There are some scattered small patches where chronic inflammatory cells are present about the blood vessels and, at one point, fairly marked about a hair follicle. The active dermatitis, however, is not marked.

The lesions in the lungs are illustrated by a peripheral section from the upper lobe of the right lung that was described as follows: The lung tissue is markedly altered, showing quite extensive patchy collapse, interstitial or interalveolar fibrosis, and a mild interalveolar and interstitial chronic inflammatory cell infiltration. Dilated bronchioles remain in these collapsed and fibrotic areas, the bronchial epithelium has extensively degenerated, and some expanded lung tissue is congested and edematous (fig. 3).

Comment

We have not located a published case of dermatomyositis in which pulmonary symptoms and signs were the presenting feature or an important part of the patient's illness. In 66 cases of such disease reported by 13 different authors,[1] pulmonary signs and symptoms were not a feature of the illness at any time, although a number of authors refer to pulmonary involvement in diffuse scleroderma. In many cases of the latter disease, the focal lesions in the lungs failed to attract the attention of the clinician, although they were evident at autopsy. Weiss and his colleagues [2] reported focal areas of fibrosis in 2 of 29 cases. Spain and Thomas [3] and also Dostrovsky [4] have described cystic sclerodermal changes with arteriolar thickening in the lungs in cases of scleroderma. Murphy and his co-authors [5] in 1941 reported the case of a 30-year-old Negro woman with typical scleroderma who was shown by roentgenographic evidence to have a chronic interstitial pneumonia. Autopsy showed extensive connective tissue proliferation and thickening of the alveolar septums, with changes in the associated blood vessels. They believed this to be the first reported case in which pulmonary lesions of scleroderma were demonstrated by roentgenogram, although such lesions had been described in autopsy reports in six previous cases. Banks [6] in his review of the collagen tissue diseases also refers to pulmonary fibrosis in scleroderma and periarteritis nodosa but does not comment on this feature in dermatomyositis.

In the present case the presenting clinical signs and symptoms both at the onset and throughout the illness were referable to the lungs. Even toward the termination of the illness, the usual features of dermatomyositis were masked. No typical skin rash was observed, although a diffuse scarlatinal type of erythema was sometimes evident. The skin never showed the wood-like edematous

characteristics of the disease in its late stages, although the generalized muscle tenderness and eosinophilia were quite typical. The widespread muscle degeneration was also reflected in the greatly increased creatine excretion. The chest roentgenograms were interpreted by the radiologist as showing chronic interstitial changes not characteristic of any one disease but found in a variety of diseases.

Treatment with both corticotropin and cortisone failed to influence the inexorable downhill course. The treatment is open to the criticism that inadequate dosages were employed. In retrospect, much larger daily amounts of corticotropin might have been employed, although the eosinophil drop indicated some physiological effect.

From the pathologist's viewpoint the lesions present in the skin and in the skeletal muscles, as well as in the myocardium, were of a nonspecific histological nature but at the same time were quite characteristic of the disease dermatomyositis. No features of lupus erythematosus were present, nor were there any significant vascular lesions such as occur in the group of necrotizing angiitides or in scleroderma. The unique occurrence of an interstitial pneumonitis and quite marked interstitial pulmonary fibrosis in this case is the one feature that may be found in scleroderma. It is one further instance of similarity of tissue reactions in various members of the group of diseases featured by degenerations or alterations in collagenous tissues. At the same time, this pulmonary fibrosis is of a nonspecific nature, quite like that frequently seen, which bears no relation to this group of disorders and is often of unknown causation.

Summary and Conclusions

Dermatomyositis may occasionally produce widespread pulmonary fibrosis. In the reported case of this disease, which is believed to be unique, lung involvement was the cause of the initial complaints and the dominant clinical signs and symptoms throughout the illness. This case affords further evidence to support the view, widely held, that collagen diseases have some common etiological background.

66 Dorchester St. E. (Dr. Mills).

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COUNCIL ON FOODS AND NUTRITION

Report of the Council

The Council has authorized publication of the following statement.

EUGENE H. STEVENSON, M.S.
Acting Secretary.

IMPORTANCE OF VITAMIN C IN THE DIET

The Council on Foods and Nutrition recognizes the importance of dependable dietary sources of vitamin C (ascorbic acid), the vitamin necessary for the prevention of scurvy. Vitamin C is important for the preservation of the normal healthy structure of the gums and soft tissues of the body and for the development of teeth and bones. It must be supplied by the diet because the human body cannot synthesize vitamin C, as can some animals. The value of citrus fruit and tomatoes as sources of vitamin C is well known. Other foods that aid in maintaining normal daily intakes of vitamin C are potatoes, various vegetables—especially greens, raw cabbage, and green peppers—berries, other fruits, and melons.

Studies have shown that the vitamin C content of fresh citrus fruits and tomatoes may show considerable variation, being dependent on many factors, including seasonal influences, variety of fruit, and degree of ripeness of fruit. Therefore, in order to insure a high vitamin C content in the juice, it is essential that fresh fruit of good quality, picked at the proper time, be used and processed in such a manner as to retain in high degree the vitamin C present in the fresh products. The importance of citrus and tomato juices as dietary sources of vitamin C has led the Council to develop certain nutritional criteria that it believes are desirable for such products.

The necessity of supplying infants with vitamin C has prompted the Council to formulate certain additional criteria believed to be of importance in orange juice especially prepared for infants. In addition to being finely strained so that it will flow through a nipple, orange juice for infant feeding should have low peel oil content in order to minimize the possibility of allergic reactions caused by this substance. Ranges for the acid content and Brix-acid ratio are designated because it is believed that the taste should not be too tart.

Citrus and tomato juices that meet the recommendations of the Council can be regarded as dependable sources of vitamin C and are suitable for use in the diets of persons of all ages.

FOOD STANDARDS

In accord with the Council's announced purpose of formulating desirable nutritional standards for classes of foods, the following recommendations for citrus and tomato juices are offered for the guidance of the medical profession, industry, and other interested parties.

EUGENE H. STEVENSON, M.S.
Acting Secretary.

Orange Juice

The Council on Foods and Nutrition believes that, in addition to conforming to the appropriate federal, state, and local regulations, processed orange juice should meet the following specifications.

1. It should conform to the definition and standard of identity of the Food and Drug Administration for grade A orange juice.

2. It should contain at least 40 mg. of vitamin C per 100 ml. of single-strength juice at the time of packing.

3. This level should be obtained by careful selection and processing rather than by the addition of synthetic ascorbic acid.

4. During the processing season, daily laboratory records should include ascorbic acid determinations in order to demonstrate the maintenance of the recommended vitamin C level.

Grapefruit Juice

The Council on Foods and Nutrition believes that, in addition to conforming to the appropriate federal, state, and local regulations, processed grapefruit juice should meet the following specifications.

1. It should conform to the definition and standard of identity of the Food and Drug Administration for grade A grapefruit juice.

2. It should contain at least 30 mg. of vitamin C per 100 ml. of single-strength juice at the time of packing.

3. This level should be obtained by careful selection and processing rather than by the addition of synthetic ascorbic acid.

4. During the processing season, daily laboratory records should include ascorbic acid determinations in order to demonstrate the maintenance of the recommended vitamin C level.

Orange-Grapefruit Blends

The Council on Foods and Nutrition believes that, in addition to conforming to the appropriate federal, state, and local regulations, a processed orange-grapefruit blend should meet the following specifications.

1. It should conform to the definition and standard of identity of the Food and Drug Administration for grade A canned blended grapefruit juice and orange juice.

2. It should contain at least 35 mg. of vitamin C per 100 ml. of single-strength juice at the time of packing.

3. This level should be obtained by careful selection and processing rather than by the addition of synthetic ascorbic acid.

4. During the processing season, daily laboratory records should include ascorbic acid determinations in order to demonstrate the maintenance of the recommended vitamin C level.

Tomato Juice

The Council on Foods and Nutrition believes that, in addition to conforming to the appropriate federal, state, and local regulations, processed tomato juice should meet the following specifications.

1. It should conform to the definition and standard of identity of the Food and Drug Administration for grade A tomato juice.

2. It should contain at least 17.5 mg. of vitamin C per 100 ml. of single-strength juice at the time of packing.

3. This level should be obtained by careful selection and processing rather than by the addition of synthetic ascorbic acid.

4. During the processing season, daily laboratory records should include ascorbic acid determinations in order to demonstrate the maintenance of the recommended vitamin C level.

Strained Orange Juice

The Council on Foods and Nutrition believes that, in addition to conforming to the appropriate federal, state, and local regulations, processed strained orange juice should meet the following specifications.

1. It should conform to the definition and standard of identity of the Food and Drug Administration for grade A orange juice with the following exceptions.

a. It should contain less than 0.02% peel oil and should be finely strained for feeding through a nipple.

b. The acidity (calculated as anhydrous citric acid) should be within the range of 0.75 to 1.20 gm. per 100 ml. of juice.

c. The Brix-acid ratio should be within the range of 13:1 to 18:1. Dextrose may be added to adjust the ratio.

2. It should contain at least 40 mg. of vitamin C per 100 ml. of juice at the time of packing.

3. This level should be obtained by careful selection and processing rather than by the addition of synthetic ascorbic acid.

4. During the processing season, daily laboratory records should include data to demonstrate the maintenance of the recommended vitamin C level and other factors mentioned.

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STUTTERING

GUEST EDITORIAL

Smiley Blanton, M.D.

The functions of speech are threefold. The first is to express emotions through tone, inflections, and words. Perhaps this is the most fundamental and important function of speech. The second is to adjust to other people. We see how tragic it is not to be able to talk with others when we observe deaf children who cannot speak. The third function, perhaps the least important, is to express ideas. Stuttering is a blocking of the person's ability to adjust to other people. It is a personality defect due to anxiety in meeting various social situations rather than a speech defect. Except in rare instances, most stutterers can talk when they are alone, they can talk to animals, and they can often talk to people they are friendly with. Stuttering, therefore, cannot be considered a speech defect, because it occurs only in situations where fear and anxiety are aroused.

Intensive studies have been made to show that there is some organic cause for stuttering, but there has never been positive evidence to prove that any neurological or anatomic deformity causes stuttering, except in very occasional cases. There have been some cases of stuttering after brain hemorrhage, but these cases are rare. It is thought that children who are left-handed and are made to write with their right hand fail to establish the speech area in one hemisphere and that there is a conflict between the two hemispheres; however, the majority of investigators do not accept this theory.

The organs used in speech are also used for other more primitive purposes, such as coughing, sneezing, sucking, breathing, and vomiting. A study of the symptoms of stuttering would seem to show that they are similar to these primitive actions, as though the person were trying to vomit, to chew, or to suck. There are about 600 speech sounds in the various languages of the world; the baby in his babble stage uses hundreds of these speech sounds, but when he begins to speak he must exclude all the sounds not used in the English language, of which there are about 56 sounds. When a child begins to speak, he has to reject many primitive sounds that he made in the baby stage. Stutterers seem to fail to make this exclusion. Analysis of stuttering shows that the symptom is a regression to the more primitive actions of the organs used in speech and a retention of the primitive sounds that must be given up when the phoneme of speech is established.

Stuttering is caused by a fear of people on the part of the stutterer. The symptoms can often be removed by suggestions to the stutterer by a strong personality. For example, a teacher told a 10-year-old girl that if she wanted to get well she should leave her window open at night. It was the custom of the child's family to close the windows at night. The child came to school the next morning without a stutter and told the teacher: "You told me to leave my window open and I would be well. I left it open last night and I am well now." In this case, the stuttering never returned.

We know that between 1% and 1.5% of people stutter. Perhaps half the children in nursery schools pass through a stuttering stage lasting a few days. The more sensitive and timid a child is, the more likely he is to have spells of stuttering. The treatment of the stutterer consists in building up his confidence, giving him loving attention, and teaching him to adjust to the group. For instance, in the case of hysterical paralysis of the hand it is helpful for the person to use the hand in various ways, but the essential treatment consists in removing the unconcious barrier that caused the paralysis. In much the same way it is helpful for the child to receive speech training such as he would receive in a good speech center or public-speaking class. However, some of the results obtained through speech training may be due more to the loving attention the child gets during the training than to the treatment itself. Some schools have various methods of treatment, such as speaking while waving the hands in the air, breathing in a certain way while speaking, or speaking in a scanning fashion.

In the case of the very young child who stutters, there is need for a reorganization of the family life so that the child will receive the right amount and kind of love and affection so as to develop a sense of security. There is no short-cut to the treatment of stuttering. When stuttering persists on into adolescence and adulthood, the person's whole personality is involved and not just the speech organs. He must be trained to understand himself and to learn to adjust to other people without fear and without tension.

From the American Foundation of Religion and Psychiatry, New York.

REINTEGRATION OF MEDICINE

Expressions of concern have become frequent regarding the rate at which young people are preparing for careers in the basic sciences. Lest anything hereinafter be construed as reflecting especially on the medical profession, be it noted that such expressions come also from engineers and from Canada as well as from the United States.[1]

Comparisons with other nations on the number of persons preparing for scientific careers are disquieting. The chairman of the U. S. Atomic Energy Commission has stated that "all of us are impressed by the disturbing fact that Russia appears to be training scientists and engineers at a faster rate than we are. Mr. Allen Dulles, the

distinguished director of our Central Intelligence Agency, has publicly stated that between 1950 and 1960 Soviet Russia will have graduated 1,200,000 scientists and engineers, compared with about 900,000 in the United States in our present program. . . . Unless corrected, this situation, a generation hence, will become a national calamity, imperiling our security and freedom in an age of expanding dependence upon science and technology." [2]

Recent articles in the *Bulletin of the Atomic Scientists* [3] remind the reader that scientists are people. They are not ants, even if they can be produced at the rate of a million per decade. The life of the research worker in nuclear physics, especially in "classified" areas of the science, is described in terms that make one wonder why a person with normal emotional needs should wish to confine himself to so bleak a mode of existence. Psychological studies [4] show that even scientific data are biased if they come from people without a healthy instinct for self-preservation. As long as people are free to choose their vocations, the setting up of unreasonable requirements for any particular profession can only discourage the sensible and increase the proportion of odd characters among those who choose it.

The tendency to require more and more years of college work as a prerequisite for admission to medical schools reached its point of diminishing returns many years ago. Possession of a bachelor's degree is by no means the only desideratum in entrants to medical schools; neither is the indefinite protraction of formal education a guarantee of a man's ultimate professional competence. It was a favorite idea of John Fiske,[5] one of the best known of American philosophers, that the evolution of man was especially due to the extraordinary prolongation of his infancy. But even Fiske did not picture a situation in which man, having increased his expectancy of life to nearly 70 years, would have increased his expectancy of education to nearly 35.

For this reason some of the manifestations that accompany the increasing specialization in medicine are worthy of study. A general practitioner refuses to perform a rectal examination and refers the patient without further ado to a specialist; orthopedists quarrel with physiatrists over the right to sign an order for an artificial leg. In some fields a man cannot be recognized until he has spent so many years of his life on premedical and medical courses, on internships and residencies, and on the acquisition of sufficient experience, means, and influence to be certified by some board that his years of greatest keenness are long past before the program is completed. These facts are no secret to the younger generation.

An earnest plea to oppose this trend has been voiced by Himsworth [6] in the 1955 Linacre Lecture. One of the Linacre ideals was that a physician should be "groundedly learned" in the arts and sciences rather than narrowly professional. Since Linacre's day new knowledge has accumulated in such profusion and variety as to threaten the intellectual unity of medicine, but an effort must nevertheless be made to prevent disintegration into narrow and exclusive specialties.

Teamwork, so often mentioned today, is not the only answer. Himsworth maintains that integration of knowledge "occurs within a man, not between men." When a group meets, the collation of thoughts must occur within the mind of one or more of the participants, not in the stenographer's report or on the tape recording. There must be men who link relevant disciplines and have a comprehensive knowledge of contiguous fields. Unless there is a respected place for such men, the nonclinical branches of medicine such as anatomy and pathology will continue to have trouble with a diminishing number of recruits. In the clinical branches, the training requirements for specialists cast into the present rigid moulds will discourage the production of any save existing types.

Acts of legislatures and decisions in the courts further tend to crystallize things that had better, at times, be kept in a state of flux. Legislators and jurists are necessarily guided by current medical opinion as to what constitutes competence in a given field. The certification of one man in, say, lienology would inevitably raise doubts as to the competence of anybody else to touch, or even look at, the spleen. To add indefinitely to the requirements that narrow a man's interests and force him to specialize will jeopardize both the quantity and quality of medical service.

The House of Delegates of the American Medical Association at the Boston Clinical Meeting, November 29 to December 2, 1955, passed resolutions containing the following passages: "The various specialty boards" should "be encouraged to reappraise the practice restrictions on the board diplomates." There should be "opposition to the division of any branch of medical practice into so-called technical and professional services. . . . The American Medical Association should continue to discourage arbitrary restrictions by hospitals against general practitioners." Other resolutions bearing on this problem will be found in the report of the Reference Committee on Insurance and Medical Service.[7] Most medical schools are making efforts to avoid excessive departmentalization. There has been emphatic protest against the idea that the training of physicians who contemplate general or family practice should be anything "different, less thorough and less exacting than is needed by those who plan to specialize." [8] Certainly the pendulum must not be allowed to swing too far in the direction of specialization, and continued thought must be given to the problem of reintegration of medicine.

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6. Himsworth, H.: The Integration of Medicine: The Endeavor of Thomas Linacre and Its Present Significance (Linacre Lecture), Brit. M. J. **2**: 217-222 (July 23) 1955.

7. Report of Reference Committee on Insurance and Medical Service, Proceedings of the Boston Clinical Meeting, J. A. M. A. **159**: 1652 (Dec. 24) 1955.

8. Background for General or Family Practice and Specialization, editorial, J. A. M. A. **159**: 609 (Oct. 8) 1955.

THE PRESIDENT'S PAGE

A MONTHLY MESSAGE

For many years I have been a member of both the American Medical Association and the American Legion. As a matter of fact, I am one of the original members of the American Legion and well aware of its philosophy. During the past few years I have become more acquainted with the many common interests these two organizations have. I am very proud to inform you that relations between the two groups have been friendly and, especially in the past year, have been further cemented.

This development is due in large measure to the suggestion made by Seaborn P. Collins, former national commander of the American Legion. In November, 1954, in an address before the House of Delegates of the American Medical Association, he suggested that the American Medical Association and the American Legion appoint liaison committees in the interest of promoting fuller understanding and harmony. Such committees were established. They met twice in 1955 and have already met once in 1956. In addition the staffs of these two organizations met twice in 1955. These meetings have been conducted in an atmosphere of friendliness and respect. As a result, I feel very strongly that greater mutual understanding has been developed.

It is important that the two organizations and their representatives concentrate on their common goals and prevent the exploitation of the few areas of disagreement. Yes, there have been some differences in the past, and there may continue to be some areas where the two organizations will take opposing positions in the future. However, these instances I am confident will not deter these groups from working together to resolve their differences. In the broad arena of public affairs the American Legion and the American Medical Association have a patriotic responsibility not only to cooperate with one another but also to provide leadership for others with the same viewpoint. Furthermore, the American Medical Association and the American Legion have so many things in common that their many areas of agreement far outstrip their areas of difference.

In the first place, the American Medical Association and the American Legion have common traditions and philosophies: Both are devoted to the traditional American ideals and principles and both have a deep and abiding faith in the American way of life. Second, both organizations, while serving their respective memberships, exist for the purpose of serving the public. Third, they have many common interests. For many years they have been working together in the field of maternal and child health; they both are striving to obtain the best medical care for veterans; they both are assisting in coping with the problem of mental illness; they both desire to improve the physical and mental health of our children and of our youth; they both are working in the fields of vocational guidance; they both have supported proposed legislation (the Bricker amendment) to prevent a treaty or other international agreement that conflicts with any provision of the Constitution from being of any force or effect; they both are strongly opposed to national compulsory health insurance; they both are fighting the menace of communism.

I think perhaps I can make my point clear by one simple statement: The first word of the name of each organization denotes its main interest: "American." Both our organizations are interested in these programs because we are interested in preserving what is best in this nation and in improving whatever can be improved—for the good of all. Sometimes our methods may differ in some degree, but we have the same goal.

I feel sure that there are very few physicians in America who have not had service in the armed forces. I urge such physicians not only to participate in the affairs of organized medicine but to take an active interest in the affairs of such organizations as the American Legion and other nonmedical organizations that are concerned with the affairs of the community and of the nation. The future of America will be determined in a large measure by those who take an active interest in it. Both the American Legion and the American Medical Association have for many years manifested their interest in the affairs of this country. Together, they can make a greater contribution for a better America for all.

ELMER HESS, M.D., Erie, Pa.

THE CHICAGO MEETING

AMERICAN MEDICAL ASSOCIATION ONE HUNDRED FIFTH ANNUAL MEETING
CHICAGO, JUNE 11-15, 1956

OFFICIAL CALL

To the Officers and Members of the American Medical Association

The 105th Annual Meeting of the American Medical Association will be held in Chicago, June 11-15, 1956.

The House of Delegates will convene at 10 a. m. Monday, June 11. In the House the representation of the various constituent associations for 1956 is as follows:

Alabama	2	Montana	1
Alaska	1	Nebraska	2
Arizona	1	Nevada	1
Arkansas	2	New Hampshire	1
California	14	New Jersey	6
Colorado	2	New Mexico	1
Connecticut	3	New York	18
Delaware	1	North Carolina	3
District of Columbia	2	North Dakota	1
Florida	3	Ohio	8
Georgia	3	Oklahoma	2
Hawaii	1	Oregon	2
Idaho	1	Pennsylvania	11
Illinois	10	Puerto Rico	1
Indiana	4	Rhode Island	1
Iowa	3	South Carolina	2
Isthmian Canal Zone	1	South Dakota	1
Kansas	2	Tennessee	3
Kentucky	2	Texas	7
Louisiana	2	Utah	1
Maine	1	Vermont	1
Maryland	2	Virginia	2
Massachusetts	6	Washington	2
Michigan	6	West Virginia	3
Minnesota	4	Wisconsin	4
Mississippi	2	Wyoming	1
Missouri	4		

The scientific sections of the American Medical Association, the Medical Corps of the Army, the Medical Corps of the Navy, the Medical Corps of the Air Force, the Public Health Service, and the Veterans Administration are entitled to one delegate each.

The Scientific Assembly of the Association will open with the General Scientific Meetings to be held Monday, June 11, starting at 9 a. m. in the morning and at 2 p. m. in the afternoon. The Inaugural Meeting, at which the President will be installed, will be held on Tuesday evening, June 12. Sections of the Scientific Assembly will meet all day Tuesday, Wednesday, and Thursday, June 12, 13, and 14, and on Friday morning, June 15, as follows:

CONVENING AT 9 A. M. THE SECTIONS ON	CONVENING AT 2 P. M. THE SECTIONS ON
Diseases of the Chest	Anesthesiology
Experimental Medicine and Therapeutics	Dermatology
General Practice	Gastroenterology and Proctology
Laryngology, Otology and Rhinology	Internal Medicine
Military Medicine	Obstetrics and Gynecology
Miscellaneous Topics: Session on Allergy	Ophthalmology
Nervous and Mental Diseases	Orthopedic Surgery
Pediatrics	Pathology and Physiology
Radiology	Physical Medicine
Surgery, General and Abdominal	Preventive and Industrial Medicine and Public Health
	Urology

The Registration Bureau, which will be located on Navy Pier, will be open from 1 to 4 p. m., Sunday, June 10, from 8:30 a. m. until 5:30 p. m., Monday, Tuesday, Wednesday, and Thursday, June 11, 12, 13, and 14, and from 8:30 a. m. to 12 noon Friday, June 15.

ELMER HESS, President.
E. VINCENT ASKEY, Speaker, House of Delegates.
GEORGE F. LULL, Secretary.

MEMBERS OF THE HOUSE OF DELEGATES

A Preliminary Roster of the Legislative Body of the American Medical Association

The list of members of the House of Delegates for the session is incomplete. Following is a list of the holdover members of the House of Delegates and of the newly elected members who have been reported to the Secretary in time to be included:

DELEGATES FROM CONSTITUENT ASSOCIATIONS

ALABAMA
J. Paul Jones, Camden
E. Bryce Robinson Jr., Fairfield

ALASKA
Milo H. Fritz, Anchorage

ARIZONA
Jesse D. Hamer, Phoenix

ARKANSAS
James M. Kolb, Clarksville
Rufus B. Robins, Camden

CALIFORNIA
Lewis A. Alesen, Los Angeles
E. Vincent Askey, Los Angeles
Donald Cass, Los Angeles
Paul D. Foster, Los Angeles
Leopold H. Fraser, Richmond
John Winston Green, Vallejo
Eugene F. Hoffman, Los Angeles
R. Stanley Kneeshaw, San Jose
J. Lafe Ludwig, Los Angeles
Frank A. MacDonald, Sacramento
Sam J. McClendon, San Diego
Robertson Ward, San Francisco
Dwight L. Wilbur, San Francisco

COLORADO
Edward E. H. Munro, Grand Junction
Kenneth C. Sawyer, Denver

CONNECTICUT
Thomas J. Danaher, Torrington
John N. Gallivan, East Hartford
Stanley B. Weld, Hartford

DELAWARE
H. Thomas McGuire, New Castle

DISTRICT OF COLUMBIA
Raymond T. Holden, Washington
Hugh H. Hussey, Washington

FLORIDA
Reuben B. Chrisman Jr., Coral Gables
Francis T. Holland, Tallahassee
Louis M. Orr, Orlando

GEORGIA
Eustace A. Allen, Atlanta
Spencer A. Kirkland, Atlanta
Charles H. Richardson, Macon

HAWAII
Harry L. Arnold Jr., Honolulu

IDAHO
Hoyt B. Woolley, Idaho Falls

ILLINOIS
Walter C. Bornemeier, Chicago
Everett P. Coleman, Canton
Harlan English, Danville
Warren W. Furey, Chicago
Percy E. Hopkins, Chicago
B. E. Montgomery, Harrisburg
J. Mather Pfeiffenberger, Alton
Charles H. Phifer, Chicago
H. Kenneth Scatliff, Chicago
C. Paul White, Kewanee

INDIANA
Eli S. Jones, Hammond
Cleon A. Nafe, Indianapolis

IOWA
Francis C. Coleman, Des Moines
Robert N. Larimer, Sioux City
Donovan F. Ward, Dubuque

KANSAS
George F. Gyell, Wichita
Laurence S. Nelson Sr., Salina

KENTUCKY
Clark Bailey, Harlan
W. Vinson Pierce, Covington

LOUISIANA
James Q. Graves, Monroe
Philip H. Jones, New Orleans

MAINE
Martyn A. Vickers, Bangor

MARYLAND
Warde B. Allan, Baltimore
Howard M. Bubert, Baltimore

MASSACHUSETTS
Lawrence R. Dame, Greenfield
Philip S. Foisie, Milton
Charles G. Hayden, West Newton
Henry F. Howe, Cohasset
Nicholas S. Scarcello, Worcester
Norman A. Welch, Boston

MICHIGAN
Wyman D. Barrett, Detroit
John S. DeTar, Milan
Willis H. Huron, Iron Mountain
William A. Hyland, Grand Rapids
Robert L. Novy, Detroit
Clarence I. Owen, Detroit

MINNESOTA
J. Arnold Bargen, Rochester
Frank J. Elias, Duluth

MISSISSIPPI
John P. Culpepper Jr., Hattiesburg
John F. Lucas, Greenwood

MISSOURI
Arthur S. Bristow, Princeton
Durward G. Hall, Springfield

MONTANA
Raymond F. Peterson, Butte

NEBRASKA
Earl F. Leininger, McCook
Joseph D. McCarthy, Omaha

NEVADA
Wesley W. Hall, Reno

NEW HAMPSHIRE
Deering G. Smith, Nashua

NEW JERSEY
C. Byron Blaisdell, Asbury Park
William F. Costello, Dover
Aldrich C. Crowe, Ocean City
J. Wallace Hurff, Newark
L. Samuel Sica, Trenton
Elmer P. Weigel, Plainfield

NEW MEXICO
H. Linton January, Albuquerque

NEW YORK
A. H. Aaron, Buffalo
Walter P. Anderton, New York
R. J. Azzari, Bronx

Herbert H. Bauckus, Buffalo
Peter J. DiNatale, Batavia
Gerald D. Dorman, New York
Edward P. Flood, Bronx
Thurman B. Givan, Brooklyn
James Greenough, Oneonta
Frederic W. Holcomb, Kingston
J. Stanley Kenney, New York
Charles H. Loughran, Brooklyn
Dan Mellen, Rome
Norman S. Moore, Ithaca
Peter M. Murray, New York
Carlton E. Wertz, Buffalo
Floyd S. Winslow, Rochester
Ezra A. Wolff, Forest Hills

NORTH CAROLINA
Elias S. Faison, Charlotte
Millard D. Hill, Raleigh
Charles F. Strosnider, Goldsboro

NORTH DAKOTA
Willard A. Wright, Williston

OHIO
Paul A. Davis, Akron
Carl A. Lincke, Carrollton
Carll S. Mundy, Toledo
L. Howard Schriver, Cincinnati
Clifford C. Sherburne, Columbus
George A. Woodhouse, Pleasant Hill
Herbert B. Wright, Cleveland

OKLAHOMA
John F. Burton, Oklahoma City

OREGON
Raymond M. McKeown, Coos Bay
Archie O. Pitman, Hillsboro

PENNSYLVANIA
James Z. Appel, Lancaster
William F. Brennan, Pittsburgh
Gilson Colby Engel, Philadelphia
William L. Estes Jr., Bethlehem
Harold B. Gardner, Harrisburg
Louis W. Jones, Wilkes-Barre
George S. Klump, Williamsport
Thomas W. McCreary, Rochester
Howard K. Petry, Harrisburg
Charles L. Shafer, Kingston
Elmer G. Shelley, North East

PUERTO RICO
F. Sánchez-Castaño, Vega Baja

RHODE ISLAND
Charles J. Ashworth, Providence

SOUTH CAROLINA
George Dean Johnson, Spartanburg
William Weston Jr., Columbia

SOUTH DAKOTA
Arthur A. Lampert, Rapid City

TENNESSEE
William C. Chaney, Memphis
Charles M. Hamilton, Nashville
Charles C. Smeltzer, Knoxville

TEXAS
Joseph B. Copeland, San Antonio
John K. Glen, Houston
Louis C. Heare, Port Arthur
Milford O. Rouse, Dallas
Troy A. Shafer, Harlingen
Truman C. Terrell, Fort Worth
James H. Wooten Jr., Columbus

UTAH
George M. Fister, Ogden

VERMONT
James P. Hammond, Bennington

VIRGINIA
Vincent W. Archer, Charlottesville
W. Linwood Ball, Richmond

WASHINGTON
R. A. Benson, Bremerton
Alvia G. Young, Wenatchee
Raymond L. Zech, Seattle

WEST VIRGINIA
Frank J. Holroyd, Princeton
Walter E. Vest, Huntington

WISCONSIN
Stephen E. Gavin, Fond du Lac
Joseph C. Griffith, Milwaukee
William D. Stovall, Madison
Dexter H. Witte, Milwaukee

WYOMING
W. Andrew Bunten, Cheyenne

DELEGATES FROM THE SECTIONS AND GOVERNMENT SERVICES

ANESTHESIOLOGY
Edward B. Tuohy, Los Angeles

DERMATOLOGY
Robert R. Kierland, Rochester, Minn.

DISEASES OF THE CHEST
Hollis E. Johnson, Nashville, Tenn.

EXPERIMENTAL MEDICINE AND THERAPEUTICS
Edgar V. Allen, Rochester, Minn.

GASTROENTEROLOGY AND PROCTOLOGY
Louis A. Buie, Rochester, Minn.

GENERAL PRACTICE
Lester D. Bibler, Indianapolis

INTERNAL MEDICINE
Charles T. Stone Sr., Galveston, Texas

LARYNGOLOGY, OTOLOGY AND RHINOLOGY
Gordon F. Harkness, Davenport, Iowa

MILITARY MEDICINE
Charles L. Leedham, Cleveland

NERVOUS AND MENTAL DISEASES
Francis M. Forster, Washington, D. C.

OBSTETRICS AND GYNECOLOGY
Ralph E. Campbell, Madison, Wis.

OPHTHALMOLOGY
William L. Benedict, Rochester, Minn.

ORTHOPEDIC SURGERY
H. Relton McCarroll, St. Louis

PATHOLOGY AND PHYSIOLOGY
Lall G. Montgomery, Muncie, Ind.

PEDIATRICS
Woodruff L. Crawford, Rockford, Ill.

PHYSICAL MEDICINE
Frank H. Krusen, Rochester, Minn.

PREVENTIVE AND INDUSTRIAL MEDICINE AND PUBLIC HEALTH
R. T. Johnstone, Los Angeles

RADIOLOGY
Byrl R. Kirklin, Rochester, Minn.

SURGERY, GENERAL AND ABDOMINAL
Grover C. Penberthy, Detroit

UROLOGY
Jay J. Crane, Los Angeles

UNITED STATES AIR FORCE
Otis O. Benson Jr.

UNITED STATES ARMY
James P. Cooney

UNITED STATES NAVY
Bruce E. Bradley

PUBLIC HEALTH SERVICE
W. Palmer Dearing

VETERANS ADMINISTRATION
Roy A. Wolford

There will be present also two student delegates from the Student American Medical Association.

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES

The Speaker of the House of Delegates, Dr. E. Vincent Askey, California, has appointed delegates to serve on the reference committees of the House at the Chicago meeting as follows:

Amendments to the Constitution and Bylaws
JAY J. CRANE, *Chairman*, Section on Urology
THOMAS M. MCCREARY, Pennsylvania
RAYMOND M. MCKEOWN, Oregon
LAURENCE S. NELSON SR., Kansas
CLIFFORD C. SHERBURNE, Ohio

Board of Trustees and Secretary, Reports of
WOODRUFF L. CRAWFORD, *Chairman*, Section on Pediatrics
GEORGE A. EARL, Minnesota
JAMES P. HAMMOND, Vermont
J. STANLEY KENNEY, New York
NORMAN A. WELCH, Massachusetts

Credentials
RAYMOND M. PETERSON, *Chairman*, Montana
H. LINTON JANUARY, New Mexico
R. T. JOHNSTONE, Section on Preventive and Industrial Medicine and Public Health
SPENCER A. KIRKLAND, Georgia
ARTHUR A. LAMPERT, South Dakota

Executive Session
JOHN F. BURTON, *Chairman*, Oklahoma
PHILIP S. FOISIE, Massachusetts
WILLIAM D. STOVALL, Wisconsin
WALTER E. VEST, West Virginia
JAMES Z. APPEL, Pennsylvania

Hygiene, Public Health, and Industrial Health
MARTYN A. VICKERS, *Chairman*, Maine
RAYMOND T. HOLDEN, District of Columbia
CLARENCE I. OWEN, Michigan
RALPH E. CAMPBELL, Section on Obstetrics and Gynecology
KENNETH C. SAWYER, Colorado

Insurance and Medical Service
JOHN K. GLEN, *Chairman*, Texas
RENATO J. AZZARI, New York
PAUL D. FOSTER, California
B. E. MONTGOMERY, Illinois
ALFRED H. ELLISON, Indiana

Legislation and Public Relations
WILLIS H. HURON, *Chairman*, Michigan
ARTHUR S. BRISTOW, Missouri
JOHN F. LUCAS, Mississippi
J. LAFE LUDWIG, California
CHARLES H. PHIFER, Illinois

Medical Education and Hospitals
GEORGE KLUMP, *Chairman*, Pennsylvania
LESTER D. BIBLER, Section on General Practice
EVERETT P. COLEMAN, Illinois
DONOVAN F. WARD, Iowa
JAMES H. WOOTEN JR., Texas

Medical Military Affairs
WILLIAM C. CHANEY, *Chairman*, Tennessee
JOSEPH B. COPELAND, Texas
RUFUS B. ROBINS, Arkansas
WILLIAM WESTON JR., South Carolina
HERBERT B. WRIGHT, Ohio

Miscellaneous Business

DEXTER H. WITTE, *Chairman*, Wisconsin
PETER J. DINATALE, New York
ROBERT R. KIERLAND, Section on Dermatology
C. BYRON BLAISDELL, New Jersey
JOSEPH C. PEDEN SR., Missouri

Reports of Officers

WILLIAM L. ESTES JR., *Chairman*, Pennsylvania
VINCENT W. ARCHER, Virginia
REUBEN A. BENSON, Washington
HOLLIS E. JOHNSON, Section on Diseases of the Chest
PHILIP H. JONES, Louisiana

Rules and Order of Business

HERBERT H. BAUCKUS, *Chairman*, New York
J. ARNOLD BARGEN, Minnesota
CARL A. LINCKE, Ohio
JESSE D. HAMER, Arizona
E. BRYCE ROBINSON JR., Alabama

Sections and Section Work

HOWARD M. BUBERT, *Chairman*, Maryland
CLARK BAILEY, Kentucky
EDWIN P. FLOOD, New York
H. KENNETH SCATLIFF, Illinois
HOYT B. WOOLLEY, Idaho

Tellers

EUSTACE A. ALLEN, *Chairman*, Georgia
CHARLES J. ASHWORTH, Rhode Island
FRANK L. FEIERABEND, Missouri
H. RELTON MCCARROLL, Section on Orthopedic Surgery
MILO H. FRITZ, Alaska

Sergeants at Arms

WILLIAM F. BRENNAN, *Master Sergeant*, Pennsylvania
H. THOMAS MCGUIRE, Delaware
C. PAUL WHITE, Illinois

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION, 1955-1956

PRESIDENT—Elmer Hess, Erie, Pa.

PRESIDENT-ELECT—Dwight H. Murray, Napa, Calif.

VICE PRESIDENT—Millard D. Hill, Raleigh, N. C.

SECRETARY AND GENERAL MANAGER—George F. Lull, Chicago.

ASST. SECRETARY—Ernest B. Howard, Chicago.

TREASURER—J. J. Moore, Chicago.

SPEAKER, HOUSE OF DELEGATES — E. Vincent Askey, Los Angeles.

VICE SPEAKER, HOUSE OF DELEGATES—Louis M. Orr, Orlando, Fla.

EDITOR—Austin Smith, Chicago.

BUSINESS MANAGER—Thomas R. Gardiner, Chicago.

BOARD OF TRUSTEES—J. P. Price, Florence, S. C., 1956; J. R. Reuling, Bayside, N. Y., 1957; J. R. McVay, Kansas City, Mo., 1957; E. S. Hamilton, Kankakee, Ill., 1958; G. Gundersen, Chairman, LaCrosse, Wis., 1958; D. B. Allman, Atlantic City, N. J., 1959; F. J. L. Blasingame, Wharton, Texas, 1959; L. W. Larson, Bismarck, N. D., 1960; T. P. Murdock, Meriden, Conn., 1960; the President and the President-Elect.

STANDING COMMITTEES OF THE HOUSE OF DELEGATES

JUDICIAL COUNCIL—W. F. Donaldson, Bakerstown, Pa., 1956; H. L. Pearson Jr., Chairman, Miami, Fla., 1957; G. A. Woodhouse, Pleasant Hill, Ohio, 1958; J. M. Hutcheson, Richmond, Va., 1959; L. A. Buie, Rochester, Minn., 1960; G. F. Lull, Secretary, Chicago.

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS—G. A. Caldwell, New Orleans, 1956; J. W. Cline, San Francisco, 1956; F. D. Murphy, Lawrence, Kan., 1957; H. G. Weiskotten, Chairman, Skaneateles, N. Y., 1957; V. Johnson, Rochester, Minn., 1958; L. S. McKittrick, Brookline, Mass., 1958; C. T. Stone Sr., Galveston, Texas, 1959; W. A. Bunten, Cheyenne, Wyo., 1959; J. M. Faulkner, Boston, 1960; H. English, Danville, Ill., 1960; E. L. Turner, Secretary, Chicago.

COUNCIL ON MEDICAL SERVICE—C. E. Wertz, Buffalo, 1956; R. L. Novy, Detroit, 1957; R. B. Chrisman Jr., Coral Gables, Fla., 1958; A. C. Scott Jr.,* Temple, Texas, 1958; J. D. McCarthy, Chairman, Omaha, 1959; H. B. Mulholland, Charlottesville, Va., 1960; W. B. Martin, Norfolk, Va.; E. Hess, Erie, Pa.; D. B. Allman, Atlantic City, N. J.; Mr. T. A. Hendricks, Secretary, Chicago.

COUNCIL ON CONSTITUTION AND BYLAWS—L. A. Buie, Chairman, Rochester, Minn., 1956; Warren W. Furey, Chicago, 1957; S. H. Osborn, Hartford, Conn., 1958; F. S. Winslow, Rochester, N. Y., 1959; B. E. Pickett Sr., Carrizo Springs, Texas, 1960; E. S. Hamilton, Kankakee, Ill.; the President and the Speaker and Vice Speaker of the House of Delegates.

STANDING COMMITTEES OF THE BOARD OF TRUSTEES

COUNCIL ON PHARMACY AND CHEMISTRY—E. M. K. Geiling, Chicago, 1956; E. M. Nelson, Washington, D. C., 1956; H. K. Beecher, Boston, 1956; T. Sollmann, Chairman, Cleveland, 1957; J. P. Leake, Washington, D. C., 1957; A. C. Curtis, Ann Arbor, Mich., 1957; W. C. Cutting, San Francisco, 1958; O. O. Meyer, Madison, Wis., 1958; M. H. Servers, Ann Arbor, Mich., 1958; T. M. Brown, Washington, D. C., 1958; J. Stokes Jr., Philadelphia, 1959; P. H. Long, Brooklyn, N. Y., 1959; W. G. Workman, Bethesda, Md., 1959; H. Eagle, Bethesda, Md., 1959; C. A. Dragstedt, Chicago, 1960; I. Starr, Philadelphia, 1960; J. Hayman, Boston, 1960; H. D. Kautz, Secretary, Chicago.

COUNCIL ON SCIENTIFIC ASSEMBLY—M. E. DeBakey, Houston, Texas, 1956; S. P. Newman, Denver, 1957; J. R. McVay, Kansas City, Mo., 1957; H. R. Viets, Boston, 1958; C. H. Phifer, Chicago, 1958; S. P. Reimann, Philadelphia, 1959; A. McMahon, Chairman, St. Louis, 1959; L. W. Larson, Bismarck, N. D., 1960; C. A. Lincke, Carrollton, Ohio, 1960; T. G. Hull, Secretary, Chicago.

COUNCIL ON MEDICAL PHYSICS—F. R. Ober, Boston, 1956; D. M. Lierle, Iowa City, 1956; W. W. Coblentz, Washington, D. C., 1957; G. M. Piersol, Philadelphia, 1957; M. A. Bowie, Swarthmore, Pa., 1958; A. L. Watkins, Boston, 1958; W. J. Zeiter, Cleveland, 1958; F. H. Krusen, Chairman, Rochester, Minn., 1959; A. C. Cipollaro, New York, 1959; F. Butte, Dallas, Texas, 1959; O. Glasser, Cleveland, 1960; S. Warren, Boston, 1960; D. Vail, Chicago, 1960; R. E. DeForest, Secretary, Chicago.

COUNCIL ON FOODS AND NUTRITION—R. Jackson, Columbia, Mo., 1956; G. R. Cowgill, Hamden, Conn., 1956; W. H. Griffith, Los Angeles, 1957; W. J. Darby, Nashville, Tenn., 1958; C. A. Elvehjem, Madison, Wis., 1958; J. B. Youmans, Nashville, Tenn., 1958; L. A. Maynard, Ithaca, N. Y., 1959; G. A. Goldsmith, New Orleans, 1959; C. S. Davidson, Chairman, Boston, 1959; C. A. Smith, Boston, 1960; D. B. Hand, Geneva, N. Y., 1960.

COUNCIL ON INDUSTRIAL HEALTH—W. P. Shepard, Chairman, New York, 1956; M. N. Newquist, New York, 1956; P. S. Richards, Salt Lake City, 1957; J. H. Sterner, Rochester, N. Y., 1957; R. T. Johnstone, Los Angeles, 1958; L. C. McGee, Wilmington, Del., 1958; C. F. Shook, Toledo, Ohio, 1958; J. N. Gallivan, East Hartford, Conn., 1959; V. C. Baird, Houston, Texas, 1959; O. A. Sander, Milwaukee, 1959; R. A. Kehoe, Cincinnati, 1960; E. S. Jones, Hammond, Ind., 1960.

COUNCIL ON NATIONAL DEFENSE—S. L. Warren, Los Angeles, 1956; H. B. Wright, Cleveland, 1956; R. A. Benson, Bremerton, Wash., 1957; P. H. Long, Brooklyn, N. Y., 1957; R. L. Sensenich, South Bend, Ind., 1958; H. C. Lueth, Evanston, Ill., 1958; H. S. Diehl, Chairman, Minneapolis, 1959; R. L. Meiling, Columbus, Ohio, 1959; C. P. Hungate, Kansas City, Mo., 1960; W. B. Martin, Norfolk, Va., 1960; Mr. F. W. Barton, Secretary, Chicago.

COUNCIL ON RURAL HEALTH—A. T. Stewart, Lubbock, Texas, 1956; R. Smith, Orange Cove, Calif., 1956; W. J. Weese, Ontario, Ore., 1957; W. A. Wright, Williston, N. D., 1957; F. S. Crockett, Chairman, Lafayette, Ind., 1958; G. F. Bond, Bat Cave, N. C., 1958; C. S. Mundy, Toledo, Ohio, 1959; C. R. Henry, Little Rock, Ark., 1959; F. A. Humphrey, Fort Collins, Colo., 1960; N. H. Gardner, E. Hampton, Conn., 1960; Mrs. A. Hibbard, Secretary, Chicago.

COUNCIL ON MENTAL HEALTH—H. T. Carmichael, Chicago, 1956; M. R. Kaufman, New York, 1957; L. H. Bartemeier, Chairman, Baltimore, 1958; W. H. Baer, Peoria, Ill., 1958; F. J. Gerty, Chicago, 1958; L. H. Smith, Philadelphia, 1959; G. E. Gardner, Boston, 1959; F. M. Forster, Washington, D. C., 1960; R. J. Plunkett, Secretary, Chicago.

COMMITTEE ON LEGISLATION—D. B. Allman, Chairman, Atlantic City, N. J., 1956; M. L. Phelps, Denver, 1956; F. C. Coleman, Des Moines, Iowa, 1957; J. E. McDonald, Tulsa, Okla., 1957; D. G. Smith, Nashua, N. H., 1958; H. English, Danville, Ill., 1958; C. Bailey, Harlan, Ky., 1959; C. L. Palmer, Harrisburg, Pa., 1959; R. B. Chrisman Jr., Coral Gables, Fla., 1960; J. L. Ludwig, Los Angeles, 1960; Mr. R. G. Van Buskirk, Secretary, Chicago.

* Deceased.

The Secretary, Assistant Secretary, and Editor are ex officio members of all standing committees.

WELCOME TO CHICAGO

For the sixth time since 1918, Chicago again welcomes physicians to the Annual Meeting of the American Medical Association, which will be held June 11 to 15. A more central and easy-to-reach metropolitan center could not have been selected for this great meeting. Situated at the Southern end of Lake Michigan in the heart of the most fertile valley on earth, Chicago is served by 22 leading trunk railroads, over which

Looking north on Michigan Avenue from near 12th Street.

trains arrive or depart every 48 seconds, bringing in about 56,000 persons through train arrivals and a daily record average of more than 300,000 commuters. Air travel to Chicago also is unexcelled. At the municipally owned Midway Airport on the Southwest side, the busiest airport in the United States, with some 15 major or feeder lines, a plane arrives or departs about every two minutes. Recently O'Hare Airport, another large one, on the Northwest side, has been opened. Unsurpassed bus service with downtown bus terminals also brings travelers from the most remote hamlets. For those who desire to come by water, there is the Great Lakes route and the route via the Mississippi and Illinois rivers and the Chicago Drainage Canal, which brings one to the very entrance of the great Navy Pier—the center of a number of activities of the A. M. A. Meeting.

Chicago is a popular meeting place for conventions. Year after year, more national and regional get-togethers of professional, fraternal, commercial, social, and religious bodies hold their meetings in Chicago than anywhere else. In the past 10 years this city has annually entertained an average of more than 1,000 meetings and trade shows, almost 50% more than its nearest competitors. One secret of Chicago's unparalleled ability to provide visitors with the utmost in comfort is its wealth of first-class hotel accommodations. There are 1,385 hotels, with a combined daily capacity for 225,000 guests, and many of the hotels are situated so that visitors will be in close touch with most activities, no matter in what section of the city they register.

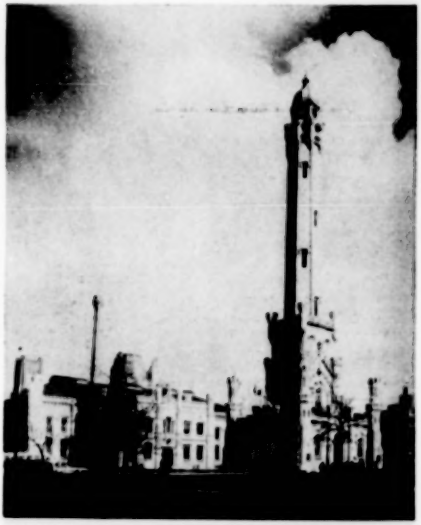
The Annual Meeting

The center of activities of the A. M. A. Annual Meeting will be at the Navy Pier, which is easily reached by bus and street car. Busses from the Pier pass the headquarters of the American Medical Association, less than a mile away. General registration for the meeting will begin at Navy Pier at 1 p. m., Sunday, June 10, and other activities will start at 8:30 Monday morning. The following activities will be at Navy Pier: the scientific exhibits, technical exposition, medical motion pictures, colored television, and the physicians' art exhibit—all on the upper floor, where continuous transportation will be provided, making it simple for physicians to go from one area of the Pier to another. The section meetings will be in the hotels and auditoriums north of the river, within walking distance or short taxi ride from Navy Pier. The general scientific meetings on Monday will be in the University of Illinois gymnasium, which is adjacent to Navy Pier. The meetings of the Section on Gastroenterology and Proctology also will be in this gymnasium.

A cordial invitation is extended to physicians to visit the headquarters of the American Medical Association at Dearborn and Grand Avenue, where guides will escort them throughout the building and explain the activities carried on there.

Medical Institutions

Chicago has five excellent medical schools: the University of Chicago, Northwestern University, the University of Illinois (which includes Rush Medical College), Loyola University Medical School, and the Chicago Medical College. Alumni of these schools may visit their alma mater and attend luncheon meetings to renew old friendships. Research institutes, which are a part of most of the universities and many of the hospitals, also will be of special interest to research workers and other medical scientists. Cook County Hospital on the West Side, one of the largest hospitals in the world, is only one of many fine hospitals in Chicago that attendants at this meeting may visit. Near Cook County Hospital, a large area is being given over to a great



The Old Water Tower marks the northerly limits reached by the great fire that practically wiped out the city in October, 1871. The carefully preserved structure is one of Chicago's most beloved landmarks.

medical center, part of which has already been constructed but the completion of which will require many more years. The Chicago Department of Health building, which is only one block from the American Medical Association headquarters, will offer an opportunity to study especially the newer methods it has put into practice and will make available visits to such institutions under municipal control as the Municipal Tuberculosis Sanatorium and the Chicago Contagious Disease Hospitals.

Historical Chicago

The United States Government, by treaty with the Indians in 1795, acquired title to an area 6 miles square at the mouth of the Chicago river and, along the river at Michigan Avenue, built Fort Dearborn in 1803-1804. Capt. John Whistler, grandfather of the famous artist, was the first commander of the fort. Markers in the street show the site of old Fort Dearborn. Chicago was incorporated as a town in 1833. The County Hospital was opened in 1847, and the first railroad came in 1848. The course of the Chicago River was reversed in 1871, providing the city with a most unusual method of disposal of sewage. The river now runs out of the lake, flowing into other waterways that form a link in the Lakes to the Gulf Waterway System. Chicago draws its water supply from several cribs built miles off shore in Lake Michigan, the first crib having been opened in 1866. The great fire, which destroyed much of the city, occurred in 1871, and the famous Water Tower that marks the northern limit of the fire still stands on Michigan Boulevard just north of Chicago Avenue. The elevated transit lines began operating in 1892, just before the World Columbian Exposition held here in 1893. Chicago now has a subway system, through which the elevated trains operate for part of their routes to different areas. The Navy Pier was completed in 1916. Today Chicago has 3,675,000 city residents and a metropolitan population approaching 5,600,000, making it America's second largest metropolis.

This bathing beach at Oak Street, immediately adjoining the Gold Coast on Chicago's Near North Side, is typical of the miles of public recreational facilities maintained by the city.

The Museum of Science and Industry in Jackson Park on Chicago's South Side is housed in the beautiful Fine Arts Building of the Columbian World's Fair of 1893. It has acres of "live" exhibits showing the relation of science to industry, including a working coal mine.

Other Attractions

Visitors never need worry about what they may do in spare time between convention sessions. There are few more attractive places for a holiday. One of the great art institutes of the world is centrally located on Michigan Avenue at Adams Street, where on some days of the week there is no admission fee. Outstanding attractions, particularly for the ladies, are the great Chicago stores, to which millions of people from all over come annually for the sole purpose of shopping on State Street. Sharing in this type of attraction are scores of specialty shops stretching southward along Michigan Boulevard from the Loop and north to the recently glorified "Magnificent Mile" that leads into the Gold Coast district. No other metropolis is more fun-loving or sports-loving. There is almost certain to be some headline athletic event, especially baseball, in the Cubs Park on the North Side or in the White Sox Park on the South Side. Many fine golf courses are on the outskirts of the city, and at least two are close by within the city limits. If you are interested in quieter entertainment, the great Field Museum in Grant Park is near the Loop. The magnificent Museum of Science and Industry in Jackson Park on the South Side, the Chicago Historical Society in Lincoln Park, the Lincoln Park Zoo, and the great Brookfield Zoo, just west of the city await your coming. For those who desire entertainment with their meals, many of the hotels and night clubs provide exceptional programs, as well as a wide variety of food prepared to please the most cultivated taste.

Downtown State Street, where practically every visitor to Chicago goes. Serving more than 500,000 customers daily, State Street's stores set the pattern for the retail world in quality and methods of salesmanship.

Grant Park at the Monroe Street Harbor, with some of Chicago's famous hotels in the background. Here, concerts are held in summer under the open skies.

HEADQUARTERS OF THE AMERICAN MEDICAL ASSOCIATION

Physicians are cordially invited to visit the headquarters of the American Medical Association at 535 N. Dearborn St., corner of Dearborn and Grand Avenue, at any time during the Annual Meeting, June 11 to 15, from 9 a. m. to 4 p. m. The building is a nine-story stone structure that houses, except for the Washington Office, most of the activities of the Association, including its printing plant. For the benefit of visitors, there is available a staff of guides who are familiar with the activities of the Association. The printing plant includes a press room, composing room, mailing room, and bindery, which occupy the first three floors and basement. On the other floors are offices for the Bureau of Medical Economic Research; the Law Department; Bureau of Exhibits; Council on Medical Service; Council on Industrial Health; Council on Pharmacy and Chemistry; Council on Medical Physics; Council on Foods and Nutrition; Chemical Laboratory; Bureau of Health Education; Bureau of Investigation; Council on Medical Education and Hospitals; Directory Department, including a biographical index of physicians; *Today's Health* Circulation Department; Office of the Secretary and General Manager; Council on National Defense; Council on Rural Health; American Medical Education Foundation; Office of the Business Manager; Advertising Department; Accounting Department; Membership and Subscription Department; Public and Press Relations Department; Office of the Editor, including News Department, Medical Literature Abstracting Department, and Manuscript Editing Department; *Today's Health* Editorial Office; Library; and the Assembly Room and Board of Trustees Room.

A. M. A. Headquarters at 535 N. Dearborn St.

Too few members of the Association are aware of the facilities at headquarters for carrying on its work. Here, for example, is the physical equipment for the printing of THE JOURNAL of the American Medical Association, the *Journal of Diseases of Children, Archives of Dermatology, Archives of Internal Medicine, Archives of Neurology and Psychiatry, Archives of Ophthalmology, Archives of Otolaryngology, Archives of Pathology, Archives of Surgery,* and *Archives of Industrial Health.* Partly because of the increased press run of THE JOURNAL and other periodicals, for some years the printing of the American Medical Directory, of the Quarterly Cumulative Index Medicus, and of *Today's Health* has been done in outside commercial printing plants. While it is realized that those who attend the Annual Meeting will be busy, it is hoped that each one of them will find at least one hour during the week to visit the Headquarters of the Association to observe for himself some of the work that is being done.

REGISTRATION

The Registration Bureau will be located at the entrance to Navy Pier and will be open from 1 to 4 p. m., Sunday, June 10, all day Monday, Tuesday, Wednesday, and Thursday, June 11, 12, 13, and 14, and until noon on Friday, June 15.

An information bureau will be operated in connection with the Registration Bureau.

Who May Register

Members—Active, Affiliate, Associate, Service, and Honorary—and invited guests may take part in the work of the sections and may register for attendance at meetings.

Active members in good standing in the American Medical Association are those members of component county medical societies and of constituent state and territorial medical associations whose names are officially reported for enrollment to the Secretary of the American Medical Association by the secretaries of the constituent medical associations and who have paid their annual American Medical Association membership dues, which this year are $25, to be paid through their constituent medical associations.

Residents, interns, senior medical students, Student A. M. A. members, and registered nurses will find special registration cards to fill in on tables near the registration windows. These should be presented, at the window indicated, together with a card or letter signed by the superintendent of the hospital where they are registered or the dean of the medical school they attend.

Register Early

Members living in the Chicago area, as well as all other physicians who are in Chicago on Sunday, should register as early as possible. They may register on Sunday, June 10, between 1 and 4 p. m.

The names and Chicago addresses of those who register will be included in the *Daily Bulletin,* and this will enable visiting physicians to find friends who have registered.

Suggestions That Will Facilitate Registration

Members who have Advance Registration Cards with pocket cards can be registered with little or no delay. They should fill in the following information prior to registration:

Hotel, number of guests, signature, and also check one scientific section.

Present filled in card with your American Medical Association Membership pocket card at windows marked "Advance Registration." Your pocket card will be returned to you, and you will receive a badge and a copy of the Official Program.

Members without Advance Registration Cards will be given blank cards to fill out, and clerks will be on hand to direct them to the proper windows for registering. They will receive a badge and a copy of the Official Program.

Registration for General Officers and Delegates At the Palmer House

General officers of the American Medical Association and members of the House of Delegates may register for the Scientific Assembly near the entrance to the Grand Ballroom at the Palmer House. This arrangement is made for the convenience of members of the House of Delegates, which will convene on Monday morning at 10 o'clock in the Grand Ballroom of the Palmer House. Delegates are requested to register for the Scientific Assembly before presenting credentials to the Reference Committee on Credentials of the House of Delegates. Registration of delegates for the Scientific Assembly will begin

at 8 o'clock Monday morning, June 11, and delegates are urged to register early so that all members of the House of Delegates may be seated in time for the opening session of the House.

If any delegate or officer is in Chicago on Saturday or Sunday, June 9 or 10, he may register for the Scientific Assembly in the Secretary's office on the Club Floor of the Palmer House.

Registration for Lay Executive Secretaries

Lay executive secretaries of component and constituent associations may register any time Saturday or Sunday, June 9 or 10, or any time *after 12 noon* Monday, June 11, during the week of the session in the Secretary's Office on the Club Floor of the Palmer House.

TRANSPORTATION

It is suggested that those physicians who contemplate traveling to Chicago to attend the annual meeting of the Association secure information concerning railroad and airplane travel directly from their local ticket agents, who are in a position to give them information regarding train or plane schedules and fares.

Special Bus Service

Special buses between Loop hotels and Navy Pier will serve those attending the Chicago meeting. Two routes have been established by the Chicago Transit Authority, one of which will serve the south Loop hotels and the other those in the northern part of the Loop. There will be express service to the Pier, at reasonable fares, every 15 minutes, from 8 to 10 a. m. and every half hour thereafter. Extra buses will be available at the Pier each afternoon during the meeting between 4:30 and 6:00 p. m. In addition, regular buses run on Grand Avenue directly to the Pier, and transfers for the Grand Avenue line may be obtained from the subway or any of the bus and streetcar lines that run North and South.

MEETING PLACES

HOUSE OF DELEGATES: Grand Ballroom, Palmer House, 15 E. Monroe St.

GENERAL SCIENTIFIC MEETINGS: Gymnasium, University of Illinois, adjacent to Navy Pier, and Room B on Navy Pier.

INAUGURAL MEETING: Civic Opera Theater, 20 N. Wacker Dr.

MOTION PICTURES: Room A, Navy Pier.

COLOR TELEVISION: Room B, Navy Pier.

GENERAL HEADQUARTERS, REGISTRATION BUREAU, SCIENTIFIC EXHIBIT, TECHNICAL EXHIBITS AND INFORMATION BUREAU: Navy Pier.

SECTIONS OF SCIENTIFIC ASSEMBLY

ANESTHESIOLOGY: Tally Ho Room, Sheraton Hotel, 505 N. Michigan Ave.

DERMATOLOGY: Ballroom, Knickerbocker Hotel, 163 E. Walton Pl.

DISEASES OF THE CHEST: Ballroom, Knickerbocker Hotel, 163 E. Walton Pl.

EXPERIMENTAL MEDICINE AND THERAPEUTICS: Ballroom, Sheraton Hotel, 505 N. Michigan Ave.

GASTROENTEROLOGY AND PROCTOLOGY: Gymnasium, University of Illinois, adjacent to Navy Pier.

GENERAL PRACTICE: Gold Coast Room, Drake Hotel, East Lake Shore Drive and North Michigan Avenue.

INTERNAL MEDICINE: Ballroom, Sheraton Hotel, 505 N. Michigan Ave.

LARYNGOLOGY, OTOLOGY AND RHINOLOGY: Thorne Hall, Northwestern University, 710 Lake Shore Dr.

MILITARY MEDICINE: Auditorium, Cinema Theater, 151 E. Chicago Ave.

MISCELLANEOUS TOPICS, SESSION ON ALLERGY: Walton Room, Drake Hotel, East Lake Shore Drive and North Michigan Avenue.

NERVOUS AND MENTAL DISEASES: Ballroom, Drake Hotel, East Lake Shore Drive and North Michigan Avenue.

OBSTETRICS AND GYNECOLOGY: Gold Coast Room, Drake Hotel, East Lake Shore Drive and North Michigan Avenue.

OPHTHALMOLOGY: Thorne Hall, Northwestern University, 710 Lake Shore Dr.

ORTHOPEDIC SURGERY: Ballroom, Lake Shore Club, 850 N. Lake Shore Dr.

PATHOLOGY AND PHYSIOLOGY: Walton Room, Drake Hotel, East Lake Shore Drive and North Michigan Avenue.

PEDIATRICS: Tally Ho Room, Sheraton Hotel, 505 N. Michigan Ave.

PHYSICAL MEDICINE: Oceanic Room, Knickerbocker Hotel, 163 E. Walton Pl.

PREVENTIVE AND INDUSTRIAL MEDICINE AND PUBLIC HEALTH: Auditorium, Cinema Theater, 151 E. Chicago Ave.

The Art Institute on the right on Michigan Avenue.

RADIOLOGY: Ballroom, Lake Shore Club, 850 N. Lake Shore Dr.

SURGERY, GENERAL AND ABDOMINAL: Gymnasium, University of Illinois, adjacent to Navy Pier.

UROLOGY: Ballroom, Drake Hotel, East Lake Shore Drive and North Michigan Avenue.

Navy Pier is located at the eastern end of Grand Avenue.

LOCAL COMMITTEE ON ARRANGEMENTS

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CO-CHAIRMEN

PERCY E. HOPKINS — F. GARM NORBURY

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Warren W. Furey — H. Prather Saunders
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Oscar Hawkinson — James P. Simonds
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James H. Hutton — J. S. Templeton
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E. M. Dewhirst — Myron J. Levin
Arthur T. Shima

One of the many Chicago beaches.

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Samuel M. Bluefarb — Harold W. Thatcher

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GEORGE C. TURNER, Chairman

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Gilbert A. Towle — M. J. Kutza
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Warner H. Newcomb — Robert A. Snyder

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Stanton A. Friedberg — Kenneth C. Johnston

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VINCENT C. FREDA, Chairman

William J. Farley — H. Close Hesseltine
Edward Burge — Carl Greenstein
Matthew E. Uznanski — J. S. Schriver
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Martha Rubin Folk — G. Henry Mundt Jr.

ORTHOPEDIC SURGERY

JOSEPH F. O'MALLEY, Chairman

John J. Fahey — Henry Heinen Jr.
Newton C. Mead

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Edwin F. Hirsch — Franklin J. Moore

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Noel G. Shaw — Ralph H. Kunstadter
J. Keller Mack — John L. Reichert
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Frederick W. Slobe
Edward C. Helfers
C. Otis Smith
Allen J. Hrejsa

Looking south from the Oak Street Beach, the Navy Pier is in the background far to the left.

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CHICAGO HOTEL RESERVATIONS

If hotel reservations have not yet been secured by physicians other than delegates or officers of the Association who expect to attend the Chicago meeting, it is suggested that such physicians fill in and send directly to A. M. A. Subcommittee on Hotels, % Chicago Convention Bureau, 134 N. LaSalle St., Suite 900, Chicago 2, Ill., the application form that may be found on advertising page 32 of this issue of THE JOURNAL. Please do *not* send applications for hotel reservations to the American Medical Association offices in Chicago. The Chicago Convention Bureau is assisting the Subcommittee on Hotels of the Local Committee on Arrangements.

HOUSE OF DELEGATES

The House of Delegates will meet at 10 a. m. Monday, June 11, 1956, in the Grand Ballroom of the Palmer House.

The Reference Committee on Credentials will meet near the entrance to the Grand Ballroom at 8:30 a. m., Monday, June 11, 1956. Credentials should be presented to the Reference Committee on Credentials as early as possible, so that the official roll of the House may be made up and so that the House of Delegates may organize promptly and proceed with its business. The Reference Committee on Credentials will also meet preceding each subsequent meeting of the House of Delegates.

Each delegate should present properly executed credentials signed by the president or secretary of the constituent association or by the chairman or secretary of the section he represents. Alternates presenting credentials should see that the delegates whose places they are to take have signed the alternate authorization.

Each delegate, *before* registering with the Reference Committee on Credentials, should register for the Scientific Assembly at a desk near the entrance to the Grand Ballroom. Rooms have been provided for the use of committees of the House of Delegates. Reference committees must have their meetings in these rooms and announce the time of their meetings, so that any who are interested in referred matters may be able to appear before the committees.

Typists will be at the service of the members of the House of Delegates for preparing official reports, resolutions, and motions in the Secretary's Office, which will be in Private Dining Rooms 15 and 16 on the Club Floor of the Palmer House.

FOR PHYSICIANS ONLY

On Wednesday and Thursday morning, June 13 and 14, from 8:30 a. m. to 12 noon, Navy Pier will be open *exclusively* for physicians to visit the Scientific and Technical Exhibits and view the Television and Motion Picture Programs. *Only physicians* wearing a physician's badge will be admitted to the Exhibits on Wednesday and Thursday morning.

INAUGURAL MEETING

Dr. Dwight H. Murray, Napa, Calif., will be inaugurated as President of the American Medical Association at special ceremonies Tuesday evening, June 12, in the Civic Opera Theater. The program will be telecast at 9 p. m. to the general public over Chicago television station WBKB, channel 7.

In addition to Dr. Murray's inaugural address, the ceremony will feature a concert by the Blue Jacket Choir from Great Lakes Naval Training Center at Great Lakes, Ill.

The Inaugural Meeting is open to physicians and their families, exhibitors, and guests.

ENTERTAINMENT

President's Reception and Ball

The President of the Association will be honored after the Inaugural Meeting with a reception and ball, to be held in the Red Lacquer Room of the Palmer House, Tuesday evening, June 12, from 10 p. m. to midnight. Members of the Association and their guests are invited to attend.

Physicians Art Exhibit

Those wishing to participate in the annual Art Exhibition are requested to notify the American Physicians Art Association before May 25. Art pieces must arrive at the exhibition area on Navy Pier adjacent to the Technical Exposition no later than June 1.

Many prizes will be awarded in both beginners and advanced classes. Beginners are those exhibiting less than three years. Already the number of registered members is the greatest in many years due to the stimulus of sponsorship by one of the country's leading pharmaceutical companies. Therefore, the Art Association's Exhibit will have a professionally planned display and spacing. All members of the American Medical Association, as well as other doctors in accredited internships and residencies, are eligible for membership. Regular dues are $5.00, sponsor dues $20.00. Sponsor membership includes the hanging fee for three pieces. The hanging fee for regular members is $5.00 per art piece and $3.00 per art piece submitted by an intern or resident. Address communications to Dr. Francis H. Redewill Jr., Secretary, 124 E. Hadley, Whittier, Calif.

Luncheons, Dinners, and Meetings of Fraternity, Alumni, and Other Organizations

ALPHA KAPPA KAPPA, Luncheon, Wednesday, June 13, 12:30, Furniture Club.

AMERICAN PHYSICIANS FELLOWSHIP COMMITTEE, Annual Assembly and Banquet, Monday, June 11, Morrison Hotel.

BOSTON UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION, Dinner, Wednesday, June 13, Palmer House.

CHRISTIAN MEDICAL SOCIETY, Annual Banquet, Thursday, June 14, 7:00 p. m., Henrici's at the Merchandise Mart. Tickets available from C. M. S. Office, 108 N. Dearborn St., Chicago, or at Navy Pier, Booth B-66.

COLLEGE OF MEDICAL EVANGELISTS ALUMNI ASSOCIATION, Dinner, Wednesday, June 13, 6:00 p. m., The Towers, Conrad Hilton Hotel.

COLLEGE OF PHYSICIANS AND SURGEONS ALUMNI ASSOCIATION (Columbia University), Dinner, Wednesday, June 13, Conrad Hilton Hotel.

CORNELL UNIVERSITY MEDICAL COLLEGE ALUMNI ASSOCIATION, Luncheon, Wednesday, June 13, 1 p. m., Palmer House. Tickets available from Alumni office, 1300 York Ave., New York 21.

DUKE UNIVERSITY MEDICAL ALUMNI ASSOCIATION, Dinner, Wednesday, June 13, 7 p. m., Saddle and Cycle Club. Tickets available from Dr. T. L. Peele, Box 3811, Duke Hospital, Durham, N. C.

FEDERATION OF CATHOLIC PHYSICIANS' GUILDS, Luncheon, Wednesday, June 13, 12:30 p. m., Sherman Hotel. Tickets available from Federation office, 1438 S. Grand Blvd., St. Louis.

GEORGETOWN MEDICAL SCHOOL, Luncheon, Wednesday, June 13, 12:30 p. m., Palmer House.

HAHNEMANN MEDICAL COLLEGE AULMNI ASSOCIATION, Dinner, Wednesday, June 13, 6:30 p. m., Bismarck Hotel. Tickets available from Alumni office, 235 N. 15th St., Philadelphia.

HARVARD MEDICAL ALUMNI ASSOCIATION, Cocktail Party, Wednesday, June 13, 5 p. m., Tavern Club.

JEFFERSON MEDICAL COLLEGE ALUMNI ASSOCIATION, Dinner, Wednesday, June 13, 6:30 p. m., Sheraton Hotel.

JOHNS HOPKINS ALUMNI ASSOCIATION, Dinner, Wednesday, June 13, 6 p. m., Palmer House. Tickets available from Alumni office, Johns Hopkins University, Baltimore 18.

LOYOLA UNIVERSITY MEDICAL ALUMNI ASSOCIATION, Dinner, Wednesday, June 13, 7 p. m., Palmer House. Tickets available from Alumni Office, 820 N. Michigan Ave., Chicago.

LUTHERAN MEDICAL MISSIONARY ASSOCIATION, Dinner, Wednesday, June 13, 6:30 p. m., Isbell's Restaurant. Also, evening meeting at Walther League.

MAYO ALUMNI ASSOCIATION, Cocktail Party, Tuesday, June 12, 6 p. m., Conrad Hilton Hotel. Tickets available from Dr. George F. Schmitt, 30 S.E. Eighth St., Miami 32, Fla.

MCGILL UNIVERSITY GRADUATES' SOCIETY, Dinner, Wednesday, June 13, 6:30 p. m., University Club of Chicago.

NORTHWESTERN UNIVERSITY ALUMNI ASSOCIATION, Luncheon, Thursday, June 14, 12:30 p. m., Abbott Hall, 710 Lake Shore Dr. Tickets available from Alumni office, 303 E. Chicago Ave., Chicago 11.

PHI BETA PI FRATERNITY, Luncheon, Wednesday, June 13, 12:30 p. m., Crystal Room, Palmer House. Tickets available from Dr. David S. Jones, 706 S. Wolcott St., Chicago 12.

PHI CHI MEDICAL FRATERNITY, Luncheon, Wednesday, June 13, 12 noon, Drake Hotel.

PHI DELTA EPSILON FRATERNITY, Open House, Wednesday, June 13, 9 p. m., Furniture Club.

PHI LAMBDA KAPPA FRATERNITY, Luncheon, Wednesday, June 13, 12 noon, Morrison Hotel.

PHI RHO SIGMA FRATERNITY, Luncheon, Wednesday, June 13, 12:30 p. m., Chicago Yacht Club. Tickets available from Dr. Howard B. Carroll, 237 E. Delaware Pl., Chicago.

RUSH MEDICAL COLLEGE ALUMNI ASSOCIATION, Luncheon, Thursday, June 14, 12:15 p. m., Morrison Hotel.

ST. LOUIS UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION, Dinner Dance, Wednesday, June 13, 7 p. m., Conrad Hilton Hotel. Tickets available from Alumni office, 1402 S. Grand Blvd., St. Louis 4.

TEMPLE UNIVERSITY MEDICAL ALUMNI ASSOCIATION, Luncheon, Thursday, June 14, 12:30 p. m., Drake Hotel.

TUFTS UNIVERSITY SCHOOL OF MEDICINE ALUMNI, Informal Cocktail Party, 6 to 7:30 p. m., Wednesday, June 13, Palmer House. Faculty members and wives invited.

UNIVERSITY OF CHICAGO MEDICAL ALUMNI ASSOCIATION, Luncheon, Thursday, June 14, 12:30 p. m., Kungsholm Scandinavian Restaurant. Tickets available from Alumni office, 100 E. Ontario St., Chicago.

UNIVERSITY OF LOUISVILLE ALUMNI ASSOCIATION, Cocktail Party and Dinner, Wednesday, June 13, 6 p. m., Palmer House. Tickets available from Alumni office, University of Louisville, Louisville 8, Ky.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI ASSOCIATION, Luncheon, Thursday, June 14, 12:30 p. m., Sheraton Hotel. Tickets available from Alumni office, 42nd and Dewey, Omaha.

UNIVERSITY OF PENNSYLVANIA MEDICAL ALUMNI SOCIETY, Cocktail Party and Dinner, Wednesday, June 13, 6 p. m., Chicago Yacht Club.

WASHINGTON UNIVERSITY MEDICAL ALUMNI ASSOCIATION, Reception, Wednesday, June 13, 5 p. m., Palmer House.

WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA, Dinner, Wednesday, June 13, 6:30 p. m., Room 107, Sherman Hotel.

WOMAN'S AUXILIARY

A cordial invitation is extended to all members of the Woman's Auxiliary to the American Medical Association, their guests, and the guests of physicians attending the Annual Meeting of the American Medical Association, to participate in all social functions and attend the general meetings of the Auxiliary.

Headquarters will be at the Conrad Hilton Hotel. Tickets for the various social functions will be available at the registration desk only. Please register early and obtain your badge and program. The registration desk will be open on Sunday, June 10, from 12 noon until 4 p. m., on Monday, Tuesday, and Wednesday, June 11, 12, and 13, from 9 a. m. to 4 p. m., and on Thursday, June 14, from 9 a. m. until 12 noon.

Preconvention Schedule

SATURDAY, JUNE 9

COMMITTEE MEETINGS

1:00 p. m. Nominating Committee—Private Dining Room No. 5 (third floor). Mrs. George Turner, Chairman.

7:30 p. m. Finance Committee—Private Dining Room No. 20 (fourth floor). Mrs. Jay G. Linn, Chairman.

SUNDAY, JUNE 10

12:00 noon to 4:00 p. m. Registration and Exhibits—Normandie Lounge (Mezzanine). Members of the Hospitality Committee will welcome members and guests of the Woman's Auxiliary during the convention.

COMMITTEE MEETINGS

10:00 a. m. Revisions Committee— Private Dining Room No. 5 (third floor). Mrs. David B. Allman, Chairman.

2:00 p. m. Resolutions Committee—Private Dining Room No. 9 (third floor). Mrs. Rollo K. Packard, Chairman.

4:00 p. m. Nominating Committee—Private Dining Room No. 10 (third floor). Mrs. George Turner, Chairman.

BOARD OF DIRECTORS MEETING AND LUNCHEON

12:00 noon Luncheon—Bel Air Room (third floor). Mrs. Mason G. Lawson, President, presiding.

2:00 p. m. Meeting—Private Dining Room No. 8 (third floor). Mrs. Mason G. Lawson, President, presiding.

MONDAY, JUNE 11

ROUND TABLE DISCUSSIONS—MEMBERS INVITED

9:00 a. m. to 10:00 a. m. Legislation—Williford Room (third floor). Mrs. Charles L. Goodhand, Chairman.

10:00 a. m. to 11:00 a. m. Organization—Williford Room (third floor). Mrs. Paul C. Craig, Chairman.

10:00 a. m. to 11:30 a. m. Bulletins and Newsletters—Private Dining Room No. 4 (third floor). Mrs. James P. Simonds, presiding.

11:00 a. m. to 12:00 noon Public Relations—Williford Room (third floor). Mrs. F. Erwin Tracy, Chairman.

1:00 p. m. to 2:00 p. m. *Today's Health*—Williford Room (third floor). Mrs. C. Rodney Stoltz, Chairman.

2:00 p. m. to 3:00 p. m. American Medical Education Foundation—Williford Room (third floor). Mrs. Frank Gastineau, Chairman.

TEA—CRYSTAL BALLROOM—SHERATON-BLACKSTONE HOTEL

3:30 p. m. to 5:30 p. m. Honoring Mrs. Mason G. Lawson, President and Mrs. Robert Flanders, President-Elect.

Special guests: Members of the National Board of Directors, National Committee Chairmen, State Presidents and Presidents-Elect, Wives of Officers, and Trustees of the American Medical Association. Hostesses: Woman's Auxiliaries to the Chicago Medical Society and the Illinois State Medical Society.

Tickets: $2.50 (including tax and gratuity)

All wives of physicians and guests are cordially invited.

Convention Program

TUESDAY, JUNE 12

8:45 a. m.

Formal opening of the 33rd Annual Convention of the Woman's Auxiliary to the American Medical Association, Grand Ballroom (Mezzanine).

INVOCATION

His Eminence Samuel Cardinal Stritch, Archbishop of Chicago.

PLEDGE OF LOYALTY

GREETINGS

Dr. F. L. Stone, President, Illinois State Medical Society.

Dr. Maurice Hoeltgen, Chairman, Local Committee on Arrangements, American Medical Association, and President, Chicago Medical Society.

ADDRESS OF WELCOME

Mrs. Warren W. Young, Immediate Past-President, Woman's Auxiliary to the Illinois State Medical Society.

RESPONSE

Mrs. L. Gardner, President, Woman's Auxiliary to the Arkansas State Medical Society.

PRESENTATION OF CONVENTION CHAIRMEN

Mrs. Leonard J. Houda and Mrs. Maurice M. Hoeltgen.

INTRODUCTIONS

Mrs. Mason G. Lawson, President.

PRESENTATION OF PRESIDENT-ELECT

Mrs. Robert Flanders.

ROLL CALL

Mrs. Carl Burkland, Constitutional Secretary.

MINUTES OF THE 32ND ANNUAL CONVENTION

Mrs. Carl Burkland.

PRESENTATION OF PROGRAM

CONVENTION RULES OF ORDER

Mrs. Arthur A. Herold.

ANNOUNCEMENT OF NATIONAL CONVENTION COMMITTEES

Mrs. Mason G. Lawson, President.

IN MEMORIAM

Mrs. Delbert MacGregor, President, Woman's Auxiliary to the Michigan State Medical Society.

ADDRESS OF THE PRESIDENT

Mrs. Mason G. Lawson.

REPORTS OF OFFICERS

President-Elect, Mrs. Robert Flanders.

First Vice-President, Mrs. Paul C. Craig.

Treasurer (and auditor's report), Mrs. George Garrison.

Constitutional Secretary, Mrs. Carl Burkland.

PRESENTATION OF NATIONAL DIRECTORS

REPORT OF BOARD OF DIRECTORS

Mrs. Mason G. Lawson.

STATE REPORTS—WESTERN REGION

Mrs. E. Arthur Underwood, Second Vice-President, Moderator.

12:30 p. m.

Luncheon in honor of the Past Presidents of the Woman's Auxiliary to the American Medical Association, Williford Room (third floor). Mrs. Mason G. Lawson, President, presiding.

Guest Speaker: Mr. Leonard E. Reed, President, Foundation for Economic Education, Inc. "The Positive Approach to Combatting Socialism."

Tickets: $4.00 (including tax and gratuity).

2:30 p. m.

STATE REPORTS—SOUTHERN REGION

Mrs. Clark Bailey, Third Vice-President, Moderator.

REPORTS OF CHAIRMEN OF STANDING COMMITTEES

American Medical Education Foundation, Mrs. Frank Gastineau.

Finance (and presentation of the Budget for 1956-1957), Mrs. Jay G. Linn.

History, Mrs. Jesse D. Hamer.

Legislation, Mrs. Charles L. Goodhand.

Organization, Mrs. Paul C. Craig.

Program, Mrs. John M. Chenault.

STATE REPORTS—NORTH CENTRAL REGION

Mrs. E. Benjamin Gillette, Fourth Vice-President, Moderator.

REPORT OF THE NOMINATING COMMITTEE FOR 1956

(First Reading), Mrs. George Turner, Chairman.

PRESENTATION OF ELECTION COMMITTEE AND TELLERS

ELECTION OF THE 1957 NOMINATING COMMITTEE

7:00 p. m.

Inaugural Meeting of the American Medical Association.

9:00 p. m.

Reception and Ball in Honor of the President of the American Medical Association.

WEDNESDAY, JUNE 13

9:00 a. m.

General Meeting of the Woman's Auxiliary to the American Medical Association, Grand Ballroom (Mezzanine). Mrs. Mason G. Lawson, President, presiding.

MINUTES

Mrs. Carl Burkland.

CONVENTION ANNOUNCEMENTS

Mrs. Leonard J. Houda.

REPORT OF TELLERS—ELECTION OF THE 1957 NOMINATING COMMITTEE

REPORTS OF CHAIRMEN OF STANDING COMMITTEES (continued)

Publications, Mrs. James P. Simonds.

Public Relations, Mrs. F. Erwin Tracy.

Revisions, Mrs. David B. Allman.

Today's Health, Mrs. C. Rodney Stoltz.

Presentation of Awards—Mr. Robert Enlow, Circulation Director, *Today's Health*.

STATE REPORTS—EASTERN REGION

Mrs. Edgar E. Quayle, Fifth Vice-President, Moderator.

REPORTS OF CHAIRMEN OF SPECIAL COMMITTEES

Bulletin Circulation, Mrs. George Cooperrider.

Civil Defense, Mrs. Paul Rauschenbach.

Mental Health, Mrs. Richard F. Stover.

Nurse Recruitment, Mrs. C. R. Pearson.

Reference, Mrs. Rollo K. Packard.

REPORT OF THE CENTRAL OFFICE

Miss Margaret N. Wolfe, Executive Secretary.

12:30 p. m.

Luncheon in honor of Mrs. Mason G. Lawson, President, and Mrs. Robert Flanders, President-Elect, Grand Ballroom (Mezzanine). Mrs. George Turner, Past National President, presiding.

Greetings: Dr. Dwight H. Murray, President, American Medical Association.

Guest Speaker: Dr. Elmer Hess, Immediate Past President, American Medical Association.

Presentation of Woman's Auxiliary Contribution to the American Medical Education Foundation: Mrs. Mason G. Lawson, President.

Presentation of A. M. E. F. Awards: Dr. George F. Lull, Vice-President, American Medical Education Foundation.

Tickets: $4.00 (including tax and gratuity).

2:30 p. m.

ROUND TABLE DISCUSSIONS—WALDORF ROOM (third floor)

Civil Defense—Mrs. Paul E. Rauschenbach, Chairman.

Program—Mrs. John M. Chenault, Chairman.

Mental Health—Mrs. Richard F. Stover, Chairman.

Nurse Recruitment—Mrs. C. R. Pearson, Chairman.

THURSDAY, JUNE 14

9:00 a. m.

General Meeting of the Woman's Auxiliary to the American Medical Association, Williford Room (third floor). Mrs. Mason G. Lawson, President, presiding.

MINUTES

Mrs. Carl Burkland.

CONVENTION ANNOUNCEMENTS

Mrs. Leonard J. Houda.

REPORT OF THE CREDENTIALS AND REGISTRATION COMMITTEE

Mrs. Charles Lesage, Chairman.

NEW BUSINESS

Revisions to the Constitution and Bylaws—Mrs. David B. Allman, Chairman.

Resolutions—Mrs. Rollo K. Packard, Chairman.

Convention Courtesy Resolutions—Mrs. Robert Dunlevy, Chairman.

REPORT OF THE NOMINATING COMMITTEE

Mrs. George Turner, Chairman.

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS

Mrs. Eustace A. Allen, Past National President.

PRESENTATION OF PAST PRESIDENT'S PIN

Mrs. Arthur A. Herold, Past National President.

PRESENTATION OF PRESIDENT'S PIN AND GAVEL

Mrs. Mason G. Lawson.

INAUGURAL ADDRESS

Mrs. Robert Flanders.

MINUTES

Mrs. Carl Burkland.

ADJOURNMENT

3:00 p. m.

Meeting of the Board of Directors, Private Dining Room No. 4 (third Floor). Mrs. Robert Flanders, President, presiding.

7:30 p. m.

Annual Dinner of the Woman's Auxiliary to the American Medical Association for members, husbands, and guests, Williford Room (third floor). Dress optional. Mrs. Leonard Houda, Convention Chairman, presiding.

Guest Speaker: Miss Ilka Chase.

FRIDAY, JUNE 15

9:00 a. m.

Postconvention Conference of National Officers, Directors, and Committee Chairmen with State Presidents and Presidents-Elect, Bel Air Room, (third floor). Mrs. Robert Flanders, President, presiding.

National Convention Committees

NOMINATING: Mrs. George Turner, Chairman, Mrs. George Garrison, Mrs. Albert F. Milford, Mrs. Louis Hundley, Mrs. Willis A. Redding, Mrs. Frank Forte, Mrs. Karl F. Ritter.

READING CONVENTION MINUTES: Mrs. James P. Simonds, Chairman, Mrs. E. M. Egan, Mrs. Arthur A. Herold, Mrs. Carl Burkland, Miss Margaret N. Wolfe.

RESOLUTIONS: Mrs. Rollo K. Packard, Chairman, Mrs. David W. Thomas, Mrs. Luther H. Kice, Mrs. Ralph B. Eusden, Mrs. Karl F. Ritter, Mrs. Arnold E. Ritt, Mrs. Paul P. Warden.

CONVENTION COURTESY RESOLUTIONS: Mrs. Robert E. Dunlevy, Chairman, Mrs. William G. Thuss, Mrs. J. S. Haley, Mrs. J. Winfred Mather, Mrs. Charles H. Flynn, Mrs. George Keller, Mrs. Oscar H. Theony.

ELECTION: Mrs. John M. Wagner, Chairman, Mrs. Richard W. Comegys, Mrs. Lawrence A. Rapee, Mrs. R. Ward Bushart, Mrs. Stanley L. Hardy, Mrs. Roy A. Douglass, Mrs. Mervin W. Glover.

TELLERS: Mrs. Martin Norgore, Chairman, Mrs. E. D. Zeman, Mrs. Walker L. Curtis, Mrs. Andrew C. Ruoff, Sr., Mrs. H. H. Fesler, Mrs. Harvey C. May, Mrs. Albert T. Sudman.

TIMEKEEPERS: Mrs. Richard C. Bellamy, Chairman, Mrs. C. A. Arneson, Mrs. Roger H. Cheney, Mrs. Charles T. Shepherd, Mrs. Warren H. Butterfield, Mrs. Isadore Zadek, Mrs. Ralph Goodwin, Sr., Mrs. Aaron E. Margulis, Mrs. E. Roland Hill, Mrs. Max Carver.

PROGRAM OF THE SCIENTIFIC ASSEMBLY

GENERAL SCIENTIFIC MEETINGS

UNIVERSITY OF ILLINOIS GYMNASIUM, NAVY PIER

Monday, June 11—9 a. m.

ALPHONSE McMAHON, St. Louis, Chairman of Council on Scientific Assembly, Presiding

Cardiac Arrhythmias

HANS HECHT, Associate Professor of Medicine, University of Utah School of Medicine, Salt Lake City, Moderator.

HOWARD B. BURCHELL, Professor of Medicine, Mayo Clinic, Rochester, Minn.

JOSEPH R. DiPALMA, Professor of Pharmacology, Hahnemann Medical College, Philadelphia.

E. STERLING NICHOL, Medical Director, Miami Heart Institute, Miami, Fla.

IRVINE H. PAGE, Research Director, Cleveland Clinic, Cleveland.

MAURICE SOKOLOW, Associate Professor of Medicine, University of California School of Medicine, San Francisco.

Monday, June 11—11 a. m.

STANLEY P. REIMANN, Philadelphia, Member of Council on Scientific Assembly, Presiding

Poliomyelitis Report

LEONARD A. SCHEELE, Surgeon General, Department of Health, Education, and Welfare, Public Health Service, Washington, D. C., Moderator.

11:00 a. m. **The Distribution of Poliomyelitis Vaccine and Its Efficacy in 1955.**
LEONARD A. SCHEELE, Washington, D. C.

11:10 a. m. **The Influence of Antigenic Potency on Degree and Duration of Vaccine Effectiveness.**
JONAS E. SALK, University of Pittsburgh School of Medicine, Pittsburgh.

11:30 a. m. **Indication for Vaccination in Poliomyelitis Based on Antibody Reactions.**
JOHN R. PAUL, School of Preventive Medicine, Yale University School of Medicine, New Haven, Conn.

11:50 a. m. **Safety and Efficacy of Poliomyelitis Vaccine from the Point of View of Present Knowledge of Pathogenesis.**
DAVID BODIAN, Poliomyelitis Laboratory, Johns Hopkins University, School of Hygiene and Public Health, Baltimore, Md.

12:10 p. m. **Discussion.**

Monday, June 11—2 p. m.

HENRY R. VIETS, Boston, Member of Council on Scientific Assembly, Presiding

Mental Health

LEO H. BARTEMEIER, Medical Director, Seton Institute, Baltimore, Md., Chairman, Council on Mental Health, American Medical Association, Moderator.

Historical Aspects of the Development of Psychiatry Within Medicine. LEO H. BARTEMEIER, Baltimore.

Psychological Handling of the Chronically Ill, the Disabled and the Incurable Patient.
FRANCIS M. FORSTER, Dean and Professor of Neurology, Georgetown University Medical Center, Washington, D. C.

The Longitudinal Pattern in Psychiatric Therapy.
LAUREN H. SMITH, Professor of Psychiatry, University of Pennsylvania School of Medicine and Graduate School of Medicine, Philadelphia.

Child Psychiatry and the General Practitioner.
GEORGE E. GARDNER, Director, Judge Baker Guidance Center; Psychiatrist-in-Chief, Children's Medical Center, Boston.

The Problem Patient: A Psychiatric Evaluation of a Thousand Cases from a Consultation Service.
M. RALPH KAUFMAN, Director, Department of Psychiatry, and STANLEY BERNSTEIN, Minnie Kastor Fellow in Psychiatry, the Mount Sinai Hospital, New York.

Monday, June 11—4 p. m.

MICHAEL E. DE BAKEY, Houston, Texas, Member of Council on Scientific Assembly, Presiding

4:00 p. m. **Some Practical Advances in Medicine for the Years 1955-1956.**
FRANK P. FOSTER, Department of Internal Medicine, Lahey Clinic, Boston.

4:30 p. m. **Recent Advances in Surgery.**
ROBERT ELMAN, Professor of Clinical Surgery, Washington University School of Medicine, St. Louis.

Friday, June 15—9 a. m.

NAVY PIER, ROOM A

SAMUEL P. NEWMAN, Denver, Member of Council on Scientific Assembly, Presiding

Medical Aspects of Crash Injuries

9:00 a. m. **The Search.** Motion picture from Cornell University Crash Injury Research Program.

9:30 a. m. **The General Medical Aspects of Automobile Crash Injuries and Deaths.**
FLETCHER D. WOODWARD, Clinical Professor of Otolaryngology, University of Virginia School of Medicine, Charlottesville.

9:40 a. m. **The Ophthalmologic Aspects.**
DUPONT GUERRY, Research Associate in Ophthalmology, Medical College of Virginia, Richmond.

9:50 a. m. **The Otological Aspects.**
LAWRENCE R. BOIES, Clinical Professor of Otolaryngology, University of Minnesota Medical School, Minneapolis.

10:00 a. m. **The Orthopedic Aspects.**
JACOB KULOWSKI, St. Joseph, Mo.

10:10 a. m. **The Psychological and Psychiatric Aspects.**
ROSS McFARLAND, Harvard School of Public Health, Boston.

10:20 a. m. **The Neurosurgical Aspects.**
HAROLD ELLIOTT, Assistant Professor of Neurosurgery, McGill University, Montreal, Que., Canada.

10:30 a. m. **The Surgical Aspects.**
FRANK H. MAYFIELD, Professor of Neurosurgery, University of Cincinnati College of Medicine, Cincinnati.

10:40 a. m. **The Industrial Aspects.**
HAROLD BRANDALEONE, Medical Director, Third Avenue Transit Corporation, New York.

10:50 a. m. **The Medical Aspects.**
SEWARD MILLER, Department of Health, Education, and Welfare, Public Health Service, Washington, D. C.

11:00 a. m. **A Surgical Summary.**
ELMER HESS, Erie, Pa., President, American Medical Association.

11:15 a. m. **A Medical Summary.**
LEONARD SCHEELE, Surgeon General, Department of Health, Education, and Welfare, Public Health Service, Washington, D. C.

THE PROGRAMS OF THE SECTIONS

OUTLINE OF THE SCIENTIFIC PROCEEDINGS

The following papers are announced to be read before the various sections. The order here is not necessarily the order that will be followed in the Official Program. The Official Program will be similar to the programs issued in previous years and will contain the final program of each section with abstracts of the papers, as well as lists of committees, program of the Inaugural Meeting, list of entertainments and other information. To prevent misunderstandings and protect the interest of advertisers, it is here announced that this Official Program will contain no advertisements. It is copyrighted by the American Medical Association and will not be distributed before the session. A copy will be given to each physician on registration.

SECTION ON ANESTHESIOLOGY

MEETS IN SHERATON HOTEL, TALLY HO ROOM

OFFICERS OF SECTION

Chairman—JOHN S. LUNDY, Rochester, Minn.

Vice Chairman—LEWIS H. WRIGHT, New York.

Secretary—DANIEL C. MOORE, Seattle.

Delegate—EDWARD B. TUOHY, Los Angeles.

Representative to Scientific Exhibit—SCOTT M. SMITH, Salt Lake City.

Executive Committee—MOSES KRAKOW, New York; RALPH S. SAPPENFIELD, Miami, Fla.; DR. LUNDY; DR. MOORE; and DR. TUOHY.

Tuesday, June 12—2 p. m.

BUSINESS MEETING; PRESENTATION OF RESOLUTIONS; REPORT OF DELEGATE; INTRODUCTION OF EXHIBITORS

Surgeon-Anesthetist Teamwork in Operating Room.
WARREN H. COLE, Chicago.
Discussion to be opened by STUART C. CULLEN, Iowa City, and B. B. SANKEY, Cleveland.

The Misuse of Topically Applied Local Anesthetics.
JOHN ADRIANI and DONOVAN CAMPBELL, New Orleans.
Discussion to be opened by DANIEL C. MOORE, Seattle.

Transtracheal Resuscitation. J. JAY JACOBY, Columbus, Ohio.
Discussion to be opened by ALBERT M. BETCHER, New York.

A Clinician's Appraisal of Local Anesthetic Drugs.
JOHN J. BONICA, Tacoma, Wash.
Discussion to be opened by ORAL B. CRAWFORD JR., Springfield, Mo.

Postoperative Study of Anesthetic Complications.
MARION G. WEITZ and BRUCE M. ANDERSON, Oakland, Calif.
Discussion to be opened by RALPH S. SAPPENFIELD, Miami, Fla.

The Role of Hypnosis in Anesthesiology.
MILTON J. MARMER, Beverly Hills, Calif.
Discussion to be opened by PAUL H. LORHAN, Kansas City, Kan.

Wednesday, June 13—2 p. m.

Chairman's Address: New Drugs and an Era of Analgesia and Amnesia.
JOHN S. LUNDY, Rochester, Minn.

The Automatic Maintenance of Anesthesia.
M. JACK FRUMIN, New York.
Discussion to be opened by F. H. VAN BERGEN, Minneapolis.

Hydroxydione (Viadril)—Observations Following One Thousand Administrations.
F. PAUL ANSBRO, ALBERT E. BLUNDELL, JOSEPH C. SWEENEY JR., Brooklyn, N. Y., and JOHN W. PILLION, Lawrence, Mass.
Discussion to be opened by JOEL B. HOBERMAN, Bethesda, Md.

The Use of Nisentil With or Without Antagonists for Supplementation or as Sole Agent of Anesthesia.
HENRY I. LIPSON and HENRY ROLLIE BRADFORD, Brooklyn, N. Y.
Discussion to be opened by FRANCIS F. FOLDES, Pittsburgh.

The Central Effect of Alphaprodine and of Chlorpromazine During Thiopental Narcosis.
VALENTINO D. B. MAZZIA, JOSEPH F. ARTUSIO JR., and ALAN VAN POZNAK, New York.
Discussion to be opened by Robert G. Hicks, New York.

Chlorpromazine: Mechanisms of Action.
ERWIN LEAR, ALBERT E. CHIRON, and IRVING M. PALLIN, Brooklyn, N. Y.
Discussion to be opened by C. R. STEPHEN, Durham, N. C.

Hypothermia in the Management of the Poor Risk Patient Undergoing Major Surgery.
S. N. ALBERT, J. SHIBUYA, M. AJWANI, W. A. SPENCER, T. D. ARMOUR JR., and J. R. THISTLETHWAITE, Washington, D. C.
Discussion to be opened by WILLIAM O. MCQUISTON, Peoria, Ill.

Thursday, June 14—2 p. m.

ELECTION OF OFFICERS

Anesthetic Management of Patients with Respiratory Disease.
NICHOLAS M. GREENE, New Haven, Conn.
Discussion to be opened by MARY KARP, Chicago.

Controlled Respiration During Cesarean Section.
WILLIAM K. BANNISTER, Hartford, Conn.
Discussion to be opened by LEROY W. KRUMPERMAN, Philadelphia.

Antifoam Agents in Pulmonary Edema.
MAX S. SADOVE, REUBEN C. BALAGOT, and ROSAURO MA. REYES, Chicago.
Discussion to be opened by KENNETH K. KEOWN, Philadelphia.

Anesthesia for Splenectomy in Patients with Blood Dyscrasias.
R. N. REYNOLDS and B. E. ETSTEN, Boston.
Discussion to be opened by ALBERT FAULCONER, Rochester, Minn.

Hemodynamic Studies During Cyclopropane Anesthesia in Humans.
MURRAY C. THOMPSON, EARL H. WOOD, and ROBERT T. PATRICK, Rochester, Minn.
Discussion to be opened by CLIFFORD J. BALDWIN JR., Evanston, Ill.

Changes in the Circulation Consequent to Intra-Abdominal Manipulation.
ANGELO G. ROCCO and LEROY D. VANDAM, Boston.
Discussion to be opened by JOHN B. DILLON, Los Angeles.

Anectine (Succinylcholine) and Inhalation Analgesia for Major Cardiac and Pulmonic Surgery.
SEYMOUR SCHOTZ, SHIRLEY S. BLOOM, and FREDERICK W. HELMSWORTH JR., Philadelphia.
Discussion to be opened by LUCIEN E. MORRIS, Seattle.

SECTION ON DERMATOLOGY

MEETS IN KNICKERBOCKER HOTEL, BALLROOM

OFFICERS OF SECTION

Chairman—J. Walter Wilson, Los Angeles.
Vice-Chairman—Ruben Nomland, Iowa City.
Secretary—Clarence S. Livingood, Detroit.
Delegate—Robert R. Kierland, Rochester, Minn.
Representative to Scientific Exhibit—Samuel M. Bluefarb, Chicago.
Executive Committee—George M. Lewis, New York; Everett C. Fox, Dallas, Texas; Dr. Wilson; Dr. Livingood; and Dr. Kierland.

Tuesday, June 12—2 p. m.

BUSINESS MEETING

The Natural History of Herpes Zoster.
Carroll F. Burgoon Jr., Philadelphia, G. Douglas Baldridge, Los Angeles, and Jane S. Burgoon, Philadelphia.
Discussion to be opened by Robert R. Kierland, Rochester, Minn.

Pyoderma Gangrenosum: A Clinical Study of Nineteen Cases.
Harold O. Perry and Louis A. Brunsting, Rochester, Minn.
Discussion to be opened by Adolph Rostenberg Jr., Chicago.

Cutaneous Sensitivity Reactions Due to Chlorpromazine.
J. Fred Mullins, Irvin M. Cohen, and E. Stanley Farrington, Galveston, Texas.
Discussion to be opened by Eugene P. Schoch Jr., Austin, Texas.

Rocky Mountain Spotted Fever.
Edward P. Cawley and Clayton E. Wheeler, Charlottesville, Va.
Discussion to be opened by J. Lamar Callaway, Durham, N. C.

Some Features Pertaining to Dermatomyositis and the Incidence of Associated Malignancy.
Charles Sheard Jr., Stamford, Conn., and Peter T. Knoepfler, Brooklyn, N. Y.
Discussion to be opened by E. Richard Harrell Jr., Ann Arbor, Mich.

Racial and Environmental Factors in Immunity to Rhus Dermatitis.
Earl R. Claiborne and Ervin H. Epstein, Oakland, Calif.
Discussion to be opened by Everett C. Fox, Dallas, Texas.

Wednesday, June 13—2 p. m.

BUSINESS MEETING: ELECTION OF OFFICERS

Primary Systemic Amyloidosis.
John G. Rukavina, Walter D. Block, and Arthur C. Curtis, Ann Arbor, Mich.
Discussion to be opened by Francis W. Lynch, St. Paul.

Chairman's Address: Dividing Lines in Specialized Medical Practice.
J. Walter Wilson, Los Angeles.

Symposium on Cosmetics

Presented in cooperation with the Committee on Cosmetics of the American Medical Association

Introduction. Raymond R. Suskind, Cincinnati.

Cutaneous Effects of Soaps and Detergents.
Raymond R. Suskind, Cincinnati.

The Rational Use of Cosmetics in Medical Practice.

1. The Emollient Creams and Their Modern Additives.
Irvin H. Blank, Boston.

2. Sunscreens and Solar Hypersensitivity: Masking Cosmetics, Protective Creams. Stephen Rothman, Chicago.

3. Depilatories and Antiperspirants.
Herbert Mescon, Boston.

Clinical Appraisal of Dermatoses Due to Cosmetic Materials.
Carl T. Nelson, New York.

Discussion by all participants.

Thursday, June 14—2 p. m.

Warty Dyskeratomas Resembling Darier's Disease.
Frederick J. Szymanski, Chicago.
Discussion to be opened by Hermann K. B. Pinkus, Monroe, Mich.

How Communicable Are Warts? Roy L. Kile, Cincinnati.
Discussion to be opened by Harvey Blank, New Brunswick, N. J.

The Treatment of Moniliasis with Nystatin.
Edwin T. Wright, James H. Graham, and Thomas H. Sternberg, Los Angeles.
Discussion to be opened by Raymond C. V. Robinson, Baltimore.

Morphea-like Epithelioma: Further Observations.
James B. Howell, Dallas, Texas, and Marcus R. Caro, Chicago.
Discussion to be opened by Phyllis E. Jones, Oklahoma City, Okla.

Psoriasis: Treatment with Riboflavin.
Merlin T. R. Maynard, San Jose, Calif.
Discussion to be opened by Carl T. Nelson, New York.

Light-Sensitive Seborrheid.
Gerald M. Frumess and Henry M. Lewis, Denver.
Discussion to be opened by Theodore Cornbleet, Chicago.

A Practical Approach to External Otitis.
Eldon T. Perry, Philadelphia.
Discussion to be opened by Ben H. Senturia, St. Louis.

SECTION ON DISEASES OF THE CHEST

MEETS IN KNICKERBOCKER HOTEL, BALLROOM

OFFICERS OF SECTION

Chairman—Edgar T. Mayer, New York.
Secretary—John F. Briggs, St. Paul.
Delegate—Hollis E. Johnson, Nashville, Tenn.
Representative to Scientific Exhibit—Edwin R. Levine, Chicago.
Executive Committee—Jay A. Myers, Minneapolis; Andrew L. Banyai, Milwaukee; Dr. Mayer; Dr. Briggs; and Dr. Johnson.

Wednesday, June 13—8:45 a. m.

BUSINESS MEETING

Surgery in Coarctation of the Aorta.
William Ray Rumel, Salt Lake City.

Panel Discussion on Practical Electrocardiography

Travis Winsor, Los Angeles, Moderator.

Participants: Joseph M. Barker, Beverly Hills, Calif.; John S. La Due and Arthur M. Master, New York; and Gordon B. Myers, Detroit.

Panel Discussion on the Value of the Routine Chest X-ray Examination

C. G. SCARBOROUGH, San Jose, Calif., Moderator.

Participants: GEORGE JACOBSON, Los Angeles; KATHARINE R. G. BOUCOT, Philadelphia; ABRAHAM MELAMED, Milwaukee; and ROBERT ANDERSON, Washington, D. C.

Thursday, June 14—9 a. m.

JOINT MEETING WITH SECTION ON RADIOLOGY IN KNICKERBOCKER HOTEL, BALLROOM

Panel Discussion on Lesions of the Upper Alimentary Tract Producing Chest Symptoms

J. PAUL MEDELMAN, St. Paul, Moderator.

Internist. ARTHUR M. OLSEN, Rochester, Minn.

Radiologists.

CLYDE A. STEVENSON, Spokane, Wash., and LESTER W. PAUL, Madison, Wis.

Surgeons.

WILLIAM M. TUTTLE, Detroit, and JOHN MAXWELL CHAMBERLAIN, New York.

Panel Discussion on Abnormalities of the Heart and the Great Vessels

CONRAD R. LAM, Detroit, Moderator.

Internists.

S. GILBERT BLOUNT JR., Denver, and F. MASON SONES JR., Cleveland.

Radiologists.

CHARLES T. DOTTER, Portland, Ore., and JOHN F. HOLT, Ann Arbor, Mich.

Surgeons.

FRANK L. A. GERBODE, San Francisco, and HENRY T. BAHNSON, Baltimore.

Friday, June 15—9 a. m.

JOINT MEETING WITH SECTION ON GENERAL PRACTICE IN DRAKE HOTEL, GOLD COAST ROOM

Arteriosclerotic Heart Disease

ANCEL KEYS, Minneapolis, Chairman

PART I. GENERAL PRACTICE

9:00 a. m. **Introduction.** ANCEL KEYS, Minneapolis.

9:10 a. m. **The Public Burden and Responsibility.** HERMAN HILLEBOE, Albany, N. Y.

9:25 a. m. **Discussion.**

9:30 a. m. **Nature Versus Nurture: Lessons from South Africa.** B. BRONTE STEWART, Cape Town, South Africa.

9:50 a. m. **Discussion.**

10:00 a. m. **Prospects for Prevention.** PAUL DUDLEY WHITE, Boston.

10:15 a. m. **General Discussion.**

10:25 a. m. **Recess.**

PART II. PROBLEMS IN PRACTICE.

10:35 a. m. **Immediate Problems of the Internist.** ROBERT L. PARKER, Rochester, Minn.

10:45 a. m. **Long-Range Problems of the Internist.** J. MURRAY STEELE, New York.

10:55 a. m. *Panel on Anticoagulants.* ROBERT L. PARKER, Rochester, Minn., Moderator.

10:55 a. m. **Early Use of Anticoagulants.** IRVING S. WRIGHT, New York.

11:05 a. m. **Later Use of Anticoagulants.** M. SUZMAN, Johannesburg, South Africa.

11:15 a. m. **Limited Use of Anticoagulants.** HENRY I. RUSSEK, New York.

11:25 a. m. **Discussion by Panelists.**

11:35 a. m. **Drugs Other than Anticoagulants.** CHARLES F. WILKINSON JR., New York.

11:50 a. m. **Question and Answers.** DRS. PARKER, RUSSEK, STEELE, SUZMAN, WILKINSON, WHITE, and WRIGHT.

SECTION ON EXPERIMENTAL MEDICINE AND THERAPEUTICS

MEETS IN SHERATON HOTEL, BALLROOM

OFFICERS OF SECTION

Chairman—THOMAS FINDLEY, Augusta, Ga.

Vice-Chairman—HARRY F. DOWLING, Hinsdale, Ill.

Secretary—GEORGE E. BURCH, New Orleans.

Delegate—HOLLIS E. JOHNSON, Nashville, Tenn.

Representative to Scientific Exhibit—JOSEPH F. ROSS, Los Angeles.

Executive Committee—IRVINE H. PAGE, Cleveland; HUGH R. BUTT, Rochester, Minn; DR. FINDLEY; DR. BURCH; and DR. JOHNSON.

Tuesday, June 12—9 a. m.

Symposium on the Management of Hypertension

Pharmacology of the Useful Antihypertensive Drugs. LAWRENCE PETERS, Kansas City, Kan.

Discussion to be opened by RAY AHLQUIST, Augusta, Ga.

Antihypertensive Drugs and the Problems of Hypertensive Disease. ARTHUR C. CORCORAN, Cleveland.

Discussion to be opened by EDGAR HINES JR., Rochester, Minn.

The Indications and Contraindications for Antihypertensive Drugs. JOHN H. MOYER, Houston, Texas.

Discussion to be opened by WILLIAM JEFFERS, Philadelphia.

The Most Effective Method of Administration of the Antihypertensive Drugs. EDWARD D. FREIS, Washington, D. C.

Discussion to be opened by CLEM BURNETT JR., Boston.

Malignant Hypertension Produced by Removing Adrenals. FLOYD R. SKELTON, Augusta, Ga.

Discussion to be opened by HANS SELYE, Montreal, Canada.

Wednesday, June 13—9 a. m.

Chairman's Address: Clinical Syndromes Produced by Isolated Dysfunctions of the Renal Tubule. THOMAS FINDLEY, Augusta, Ga.

George Minot Lecture: Porphyrin Metabolism in the Anemias. CECIL J. WATSON, Minneapolis.

The Mechanism and Significance of Proteinuria. ALVIN L. SELLERS, Los Angeles.

Discussion to be opened by WILLIAM DOCK, Brooklyn, N. Y.

The Identification and Clinical Significance of Renal Casts. GEORGE SCHREINER, Washington, D. C.

Discussion to be opened by EMANUEL H. BRESLER, New Orleans.

Simple Renal Function Tests of Clinical Usefulness.
ROBERT M. KARK, Chicago.
Discussion to be opened by ELLIOT V. NEWMAN, Nashville, Tenn.

Thursday, June 14—2 p. m.

JOINT MEETING WITH SECTION ON INTERNAL MEDICINE IN SHERATON HOTEL, BALLROOM

Symposium on Hematology

Pathogenesis and Treatment of Macrocytic Anemia in the Light of Information Obtained with Radioactive B...
C. LOCKARD CONLEY and JULIUS R. KREVANS, Baltimore.
Discussion to be opened by FRANK H. BETHELL, Ann Arbor, Mich.

Mechanism and Treatment of Iron Deficiency Anemia.
ALEXANDER R. STEVENS JR., Seattle.
Discussion to be opened by ELMER BROWN, St. Louis.

Abnormal Forms of Hemoglobin from a Genetic Point of View.
JAMES V. NEEL, Ann Arbor, Mich.
Discussion to be opened by WOLF W. ZUELZER, Detroit.

Blood Disorders Caused by Drug Sensitivity.
MAXWELL M. WINTROBE and G. E. CARTWRIGHT, Salt Lake City.
Discussion to be opened by JOHN D. BATTLE JR., Cleveland.

Newer Agents in the Treatment of Leukemia.
JOSEPH H. BURCHENAL, New York.
Discussion to be opened by BRUCE K. WISEMAN, Columbus, Ohio.

The Hemolytic Anemias—Congenital, Hereditary, and Acquired.
THOMAS HALE HAM, RUSSELL WEISMAN JR., and CARL F. HINZ JR., Cleveland.
Discussion to be opened by SCOTT N. SWISHER, Rochester, N. Y.

SECTION ON GASTROENTEROLOGY AND PROCTOLOGY

MEETS IN UNIVERSITY OF ILLINOIS GYMNASIUM, NAVY PIER

OFFICERS OF SECTION

Chairman—LOWELL D. SNORF, Evanston, Ill.
Vice-Chairman—ROBERT A. SCARBOROUGH, San Francisco.
Secretary—EVERETT D. KIEFER, Boston.
Delegate—LOUIS A. BUIE, Rochester, Minn.
Representatives to Scientific Exhibit—WILLIAM H. DEARING, Rochester, Minn., and WILLARD H. BERNHOFT, Buffalo.
Executive Committee—DONOVAN C. BROWNE, New Orleans; HARRY E. BACON, Philadelphia; DR. SNORF; DR. KIEFER; and DR. BUIE.

Tuesday, June 12—2 p. m.

Ileocolitis.
HARRY YARNIS, RICHARD H. MARSHAK, and BURRILL B. CROHN, New York.
Discussion to be opened by CHARLES B. RIPSTEIN, New York, and J. ARNOLD BARGEN, Rochester, Minn.

Colitis.
SIDNEY M. FIERST, ABRAHAM A. LANGSAM, EDWARD J. ROBINSON, ALFRED P. INGEGNO, and ABRAHAM WERNER, Brooklyn, N. Y.
Discussion to be opened by JOSEPH B. KIRSNER, Chicago, BERNARD D. ROSENAK, Indianapolis.

A Critical Analysis of Intestinal Antisepsis.
EDGAR J. POTH, Galveston, Texas.
Discussion to be opened by LAWRENCE S. MANN, Chicago; WILLIAM H. DEARING, Rochester, Minn.; and WILLIAM G. ANLYAN, Durham, N. C.

Postoperative Staphylococcic Enteritis.
R. B. TURNBULL JR., Cleveland.
Discussion to be opened by NEIL W. SWINTON, Boston; PETER A. ROSI, Chicago; and EDWARD S. JUDD JR., Rochester, Minn.

Panel on Present Trends in the Treatment of Duodenal Ulcer
WALTER L. PALMER, Chicago, Moderator.
Participants: GEORGE CRILE JR., Cleveland; JOSEPH B. KIRSNER, and ERWIN LEVIN, Chicago; SAMUEL F. MARSHALL, Boston; and JAMES L. A. ROTH, Philadelphia.

Wednesday, June 13—2 p. m.

ELECTION OF OFFICERS

The Diagnosis of Schistosomiasis Mansoni by Sigmoidoscopy and Rectal Biopsy. BENJAMIN W. WARNER, New York.
Discussion to be opened by HENRY E. MELLENEY, New Orleans; ROBERT T. LYONS, Pontiac, Mich.; and ROBERT DIMMETTE, Bethesda, Md.

Chairman's Address: Emotional Factors in Gastrointestinal Disorders. LOWELL D. SNORF, Evanston, Ill.

Symposium on Massive Gastrointestinal Bleeding

Gastrointestinal Hemorrhage as Seen by the Proctologist.
BYRON D. WILKINS, Allentown, Pa.
Discussion to be opened by A. W. MARTIN MARINO, Brooklyn, N. Y., and CARL S. HOAR JR., Boston.

Early Diagnosis in Massive Upper Gastrointestinal Bleeding.
IRVING B. BRICK, Washington, D. C.
Discussion to be opened by CLIFFORD J. BARBORKA, Chicago; JAMES L. A. ROTH, Philadelphia; and EMANUEL M. RAPPAPORT, Jamaica, N. Y.

The Management of Hemorrhaging Gastroduodenal Ulcer.
C. WILMER WIRTS JR. and TIBOR BODI, Philadelphia.
Discussion to be opened by RALPH COLP, New York, and TATE MILLER, Dallas, Texas.

The Management of Hemorrhage from Esophagogastric Varices.
CHARLES G. CHILD III, ARTHUR J. DONOVAN, and HOUTZ G. STEENBURG, Boston.
Discussion to be opened by ARTHUR H. BLAKEMORE, New York, and G. A. HALLENBECK, Rochester, Minn.

Thursday, June 14—2 p. m.

JOINT MEETING WITH SECTION ON PATHOLOGY AND PHYSIOLOGY IN UNIVERSITY OF ILLINOIS GYMNASIUM, NAVY PIER

Tropical Sprue: Diagnosis and Treatment.
FRANK H. GARDNER, Boston.

Nontropical Sprue: Diagnosis and Treatment.
MANDRED W. COMFORT and ERIC E. WOLLAEGER, Rochester, Minn.
Discussion to be opened by TOM D. SPIES, Birmingham, Ala.; DAVID ADLERSBERG, New York; GEORGE J. BAYLIN, Durham, N. C.; and JAMES A. HALSTED, Syracuse, N. Y.

Toxic Effects of Chlorpromazine: Hepatitis and Agranulocytosis.
WALLIS L. CRADDOCK, Fort Douglas, Utah.
Discussion to be opened by JOHN R. KELSEY, Houston, Texas, and RICHARD B. CAPPS, Chicago.

The Diagnostic Usefulness of Alkaline Phosphatase in Nonjaundiced Patients with Hepatobiliary Disease.
THOMAS B. GIBBONS, Seattle.
Discussion to be opened by HARRY SHAY, Philadelphia, and ROBERT M. KARK, Chicago.

Clinical-Pathological Panel Discussion on Acute Conditions in the Upper Abdomen

Internist. FRANK W. JONES, Chicago.

Surgeon. JOHN T. REYNOLDS, Chicago.

Pathologist. EDWIN F. HIRSCH, Chicago.

SECTION ON GENERAL PRACTICE

MEETS IN DRAKE HOTEL, GOLD COAST ROOM

OFFICERS OF SECTION

Chairman—I. PHILLIPS FROHMAN, Washington, D. C.

Vice-Chairman—GEORGE L. TEORPE, Wichita, Kan.

Secretary—E. I. BAUMGARTNER, Oakland, Md.

Delegate—LESTER D. BIBLER, Indianapolis.

Representative to Scientific Exhibit—CHARLES E. MCARTHUR, Olympia, Wash.

Executive Committee—FREDERICK S. EWENS, Manhattan Beach, Calif.; LOWRY H. MCDANIEL, Tyronza, Ark.; DR. FROHMAN; DR. BAUMGARTNER; and DR. BIBLER.

Tuesday, June 12—9 a. m.

BUSINESS MEETING; REPORT OF DELEGATE; INTRODUCTION OF RESOLUTIONS

Chairman's Address: The Role of the General Physician in the Atomic Age. I. PHILLIPS FROHMAN, Washington, D. C.

Panel Conference and Symposium on Endocrine Problems as Encountered in General Practice

HENRY H. TURNER, Oklahoma City, Moderator.

Participants: WILLARD M. ALLEN, St. Louis; ROBERT B. GREENBLATT, Augusta, Ga.; HANS LISSER, San Francisco; E. PERRY MCCULLAGH, Cleveland; RULON W. RAWSON, New York; and EDWARD C. REIFENSTEIN JR., New York.

Wednesday, June 13—9 a. m.

ELECTION OF OFFICERS

Medical Evaluation of the Beck Operation for Coronary Artery Disease.
BERNARD L. BROFMAN and MORTIMER L. SIEGEL, Cleveland.

The Diagnosis and Treatment of Vesicular Eruptions of the Hands. STURE A. M. JOHNSON, Madison, Wis.

Preoperative and Postoperative Care. PHILIP THOREK, Chicago.

Early Diagnosis of Carcinoma of the Stomach.
HU C. MYERS, Philippi, W. Va.

Miltown in Rheumatic Diseases. RICHARD T. SMITH, Philadelphia.

Parkinson's Disease: Therapeutic Exercises in Its Management.
DONALD J. ERICKSON, EDWARD C. CLARK, DONALD W. MULDER, COLLIN S. MACCARTY, and BETTY G. CLEMENTS, Rochester, Minn.

Placebo Response of Patients with Rheumatic Arthritis.
EUGENE F. TRAUT, Oak Park, Ill.

Friday, June 15—9 a. m.

JOINT MEETING WITH SECTION ON DISEASES OF THE CHEST IN DRAKE HOTEL, GOLD COAST ROOM

Arteriosclerotic Heart Disease

ANCEL KEYS, Minneapolis, Chairman

PART I. GENERAL PRACTICE.

9:00 a. m. **Introduction.** ANCEL KEYS, Minneapolis.

9:10 a. m. **The Public Burden and Responsibility.**
HERMAN HILLEBOE, Albany, N. Y.

9:25 a. m. **Discussion.**

9:30 a. m. **Nature Versus Nurture: Lessons from South Africa.**
B. BRONTE STEWART, Cape Town, South Africa.

9:50 a. m. **Discussion.**

10:00 a. m. **Prospects for Prevention.**
PAUL DUDLEY WHITE, Boston.

10:15 a. m. **General Discussion.**

10:25 a. m. **Recess.**

PART II. PROBLEMS IN PRACTICE.

10:35 a. m. **Immediate Problems of the Internist.**
ROBERT L. PARKER, Rochester, Minn.

10:45 a. m. **Long-Range Problems of the Internist.**
J. MURRAY STEELE, New York.

10:55 a. m. *Panel on Anticoagulants.*
ROBERT L. PARKER, Rochester, Minn., Moderator.

10:55 a. m. **Early Use of Anticoagulants.**
IRVING S. WRIGHT, New York.

11:05 a. m. **Later Use of Anticoagulants.**
M. SUZMAN, Johannesburg, South Africa.

11:15 a. m. **Limited Use of Anticoagulants.**
HENRY I. RUSSEK, New York.

11:25 a. m. **Discussion by Panelists.**

11:35 a. m. **Drugs Other than Anticoagulants.**
CHARLES F. WILKINSON JR., New York.

11:50 a. m. **Questions and Answers.**
DRS. PARKER, RUSSEK, STEELE, SUZMAN, WILKINSON, WHITE, and WRIGHT.

SECTION ON INTERNAL MEDICINE

MEETS IN SHERATON HOTEL, BALLROOM

OFFICERS OF SECTION

Chairman—HENRY M. THOMAS JR., Baltimore.

Vice-Chairman—OVID O. MEYER, Madison, Wis.

Secretary—A. CARLTON ERNSTENE, Cleveland.

Delegate—CHARLES T. STONE SR., Galveston, Texas.

Representative to Scientific Exhibit—HENRY T. RICKETTS, Chicago.

Executive Committee—HERRMAN L. BLUMGART, Boston; HOWARD P. LEWIS, Portland, Ore.; DR. THOMAS; DR. ERNSTENE; and DR. STONE.

Tuesday, June 12—2 p. m.

Cerebral Vascular Insufficiency: An Explanation of the Transient Stroke.
ELIOT CORDAY, Los Angeles, and SANFORD ROTHENBERG, San Diego, Calif.
Discussion to be opened by GEZA DE TAKATS, Chicago.

The Nature of Man's Adaptation to His Total Environment and the Relation of This to Illness.
LAWRENCE E. HINKLE JR. and HAROLD G. WOLFF, New York.
Discussion to be opened by DAVID E. ROGERS, New York.

The Billings Lecture: The Natural History of Disease.
WILLIAM S. MIDDLETON, Washington, D. C.

The Use of the TSH Test in the Diagnosis of Thyroid Disease.
PENN G. SKILLERN, Cleveland, and BURTIS R. EVANS, Salt Lake City.
Discussion to be opened by WILLIAM McK. JEFFERIES, Cleveland.

Panel Discussion on Diagnosis and Treatment of Disorders of the Anterior Pituitary

E. H. RYNEARSON, Rochester, Minn., Moderator.

Participants: D. B. ASTWOOD, Boston; OLAF H. PEARSON, New York; and ROBERT H. WILLIAMS, Seattle.

Wednesday, June 13—2 p. m.

ELECTION OF OFFICERS

Natural History of Glomerular Nephritis: A Report of Patients Treated from Ten to Twenty-Five Years After the Acute Stage.
FRANCIS D. MURPHY and EARL G. SCHULZ, Milwaukee.
Discussion to be opened by A. C. CORCORAN, Cleveland.

Therapeutic Considerations in Chronic Lymphocytic Leukemia, with Special Reference to the Natural Course of the Disease.
ANTHONY V. PISCIOTTA and JOHN S. HIRSCHBOECK, Milwaukee.
Discussion to be opened by FRANK J. HECK, Rochester, Minn.

Chairman's Address: The Effect of Thyroid Hormone on the Circulation. HENRY M. THOMAS JR., Baltimore.

Emotional Factors in Coronary Occlusion.
EDWARD WEISS, BARNEY DLIN, HENRY R. ROLLIN, H. KEITH FISCHER, and C. R. BEPLER, Philadelphia.
Discussion to be opened by OGLESBY PAUL, Chicago.

Is the Postcommissurotomy Syndrome of Rheumatic Origin?
SAMUEL EPSTEIN, Brooklyn, N. Y.
Discussion to be opened by GENE H. STOLLERMAN, Chicago.

Aortic Commissurotomy: Selection, Technique, and Results.
CHARLES P. BAILEY and WILLIAM LIKOFF, Philadelphia.
Discussion to be opened by GEORGE C. GRIFFITH, Los Angeles.

Thursday, June 14—2 p. m.

JOINT MEETING WITH SECTION ON EXPERIMENTAL MEDICINE AND THERAPEUTICS IN SHERATON HOTEL, BALLROOM

Symposium on Hematology

Pathogenesis and Treatment of Macrocytic Anemia in the Light of Information Obtained with Radioactive B...
C. LOCKARD CONLEY and JULIUS R. KREVANS, Baltimore.
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Mechanism and Treatment of Iron Deficiency Anemia.
ALEXANDER R. STEVENS JR., Seattle.
Discussion to be opened by ELMER BROWN, St. Louis.

Abnormal Forms of Hemoglobin from a Genetic Point of View.
JAMES V. NEEL, Ann Arbor, Mich.
Discussion to be opened by WOLF W. ZUELZER, Detroit.

Blood Disorders Caused by Drug Sensitivity.
MAXWELL M. WINTROBE and G. E. CARTWRIGHT, Salt Lake City.
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Newer Agents in the Treatment of Leukemia.
JOSEPH H. BURCHENAL, New York.
Discussion to be opened by BRUCE K. WISEMAN, Columbus, Ohio.

The Hemolytic Anemias—Congenital, Hereditary, and Acquired.
THOMAS HALE HAM, RUSSELL WEISMAN JR., and CARL F. HINZ JR., Cleveland.
Discussion to be opened by SCOTT N. SWISHER, Rochester, N. Y.

SECTION IN LARYNGOLOGY, OTOLOGY AND RHINOLOGY

MEETS IN NORTHWESTERN UNIVERSITY, THORNE HALL

OFFICERS OF SECTION

Chairman—JOHN R. LINDSAY, Chicago.
Vice-Chairman—JAMES W. McLAURIN, Baton Rouge, La.
Secretary—HUGH A. KUHN, Hammond, Ind.
Delegate—GORDON F. HARKNESS, Davenport, Iowa.
Representative to Scientific Exhibit—WALTER E. HECK, San Francisco.
Executive Committee—SAM H. SANDERS, Memphis Tenn.; FRANCIS W. DAVISON, Danville, Pa.; DR. LINDSAY; DR. KUHN; and DR. HARKNESS.

Tuesday, June 12—9 a. m.

Address by Honorary Chairman.
GORDON F. HARKNESS, Davenport, Iowa.

Four Case Reports

1. **Introduction of a New Instrument for Removing a Postnasal Pack.**
BERNARD WESTON, Detroit.
2. **Mass in the Neck.** DANIEL S. DESTIO, Pittsburgh.
3. **Cancer of the Middle Ear in Patient with Long-Standing External Otitis.** ALAN L. SPARKS, Indianapolis.
4. **Nail in Duodenum Removed with Intraluminal and Extracorporeal Magnets.**
MURDOCK EQUEN, GEORGE ROACH, ROBERT BROWN, and TRUETT BENNETT, Atlanta, Ga.

Diagnosis and Treatment of the Congenital Ear Atresias.
A. BUSTAMANTE GURRIA and LEO DEUTSCH, Mexico City, Mexico.

Fractures of the Facial, Orbital, Maxillary Bones, and Their Management. GUY W. SMITH, Denver.
Discussion to be opened by GERSON LOWENTHAL, Cincinnati, and HAROLD G. TABB, New Orleans.

Conservation of Hearing: Fenestration or Stapedial Mobilization.
C. M. KOS, Iowa City.
Discussion to be opened by JULIUS LEMPERT and SAMUEL ROSEN, New York, and SHIRLEY BARON, San Francisco.

Wednesday, June 13—9 a. m.

Chairman's Address: JOHN R. LINDSAY, Chicago.

Occupational Deafness. MEYER S. FOX, Milwaukee.
Discussion to be opened by ARAM GLORIG, Los Angeles, and BRUCE PROCTOR, Detroit.

Modern Treatment of Sinusitis.
WILLIAM THOMAS BRYAN, St. Louis
Discussion to be opened by FRANCIS W. DAVISON, Danville, Pa., and ROBERT MARTIN, Zanesville, Ohio.

Clinical Evaluation of Food Sensitization in Perennial Nasal Allergy. S. C. MISSAL, Cleveland.
Discussion to be opened by LAWRENCE J. HALPIN, Cedar Rapids, Iowa, and EUGENE DERLACKI, Chicago.

Symposium on a Tonsil and Adenoid Problem

General Indication and Choice of Treatment, and Relation of Tonsillectomy to Poliomyelitis.
THOMAS C. GALLOWAY, Evanston, Ill.

Surgery Versus Irradiation in Treatment of Tonsils and Adenoids. SHIRLEY H. BARON, San Francisco.

Comparison of Surgical Removal with X-Ray Treatment.
JACK A. WEISS, Chicago.

Irradiation in the Treatment of Lymphoid Tissue in the Pharynx.
JAMES W. J. CARPENDER, Chicago.

Possible Association of Irradiation and Carcinoma of Thyroid in Children. DWIGHT E. CLARK, Chicago.

Carcinoma of the Thyroid. LEO ZIMMERMAN, Chicago.

Thursday, June 14—9 a. m.

Carcinoma of the Nose and Paranasal Sinuses.
KENNETH D. DEVINE, Rochester, Minn.
Discussion to be opened by HAROLD F. SCHUKNECHT, Detroit.

Carcinoma of the Larynx: Survey of 25 Years' Experience in Treatment by Surgery and Irradiation.
CHEVALIER L. JACKSON, CHARLES M. NORRIS, JOHN V. BLADY, and ROBERT ROBBINS, Philadelphia.
Discussion to be opened by STANTON FRIEDBERG, Chicago.

Symposium on Otolaryngologic Therapy

JAMES MILTON ROBB, Detroit, Moderator.

Treatment of Tinnitus. CLARENCE W. ENGLER, Cleveland.

Treatment of Sinusitis. KENNETH L. CRAFT, Indianapolis.

Hormones in Treatment of Otolaryngologic Disease, Particularly the Use of ACTH and Cortisone. MAX SAMTER, Chicago.

Summary. FRANCIS L. LEDERER, Chicago.

BUSINESS MEETING

SECTION ON MILITARY MEDICINE

MEETS IN CINEMA THEATER, 151 E. CHICAGO AVE.

OFFICERS OF SECTION

Chairman—H. LAMONT PUGH, Bethesda, Md.
Vice-Chairman—RUSSEL V. LEE, Palo Alto, Calif.
Secretary—CECIL L. ANDREWS, Washington, D. C.
Delegate—CHARLES L. LEEDHAM, Cleveland.
Representative to Scientific Exhibit—ROBERT V. SCHULTZ, Washington, D. C.
Executive Committee—HARRY G. ARMSTRONG, Washington, D. C.; I. S. RAVDIN, Philadelphia; DR. PUGH; DR. ANDREWS; and DR. LEEDHAM.

Tuesday, June 12—9 a. m.

Chairman's Address: Principles of Preparedness.
H. LAMONT PUGH, Bethesda, Md.

Army Concepts on Medical Management of Casualties from Mass Destruction Weapons.
ROBERT L. HULLINGHORST, Washington, D. C.
Discussion to be opened by JACK MASUR and CARL L. HANSEN JR., Washington, D. C.

Biological Effects of Cosmic Radiation.
DAVID G. SIMONS, Holloman Air Force Base, N. Mex.
Discussion to be opened by WEBB E. HAYMAKER, Washington, D. C., and HUBERTUS STRUGHOLD, Randolph Field, Texas.

The Preservation of Whole Blood by Rapid Freezing.
HAROLD T. MERYMAN, J. W. HOLLINGSWORTH, and E. KAFIG, New Haven, Conn.
Discussion to be opened by IVAN W. BROWN JR., Durham, N. C., and WILLIAM H. CROSBY, Washington, D. C.

Necessary Compromises in Burn Therapy for Mass Casualties. ROBERT D. PILLSBURY and CURTIS P. ARTZ, Fort Sam Houston, Texas.
Discussion to be opened by TRUMAN G. BLOCKER, Galveston, Texas, and DONALD W. MILLER, Newport, R. I.

Cardiovascular Effects of Pressure Breathing with Graded Degrees of Compensation.
TERENCE F. MCGUIRE, G. DOUGLAS TALBOTT, STANLEY C. WHITE, and DONALD A. ROSENBAUM, Dayton, Ohio.
Discussion to be opened by DAVID G. GILLESPIE, Pensacola, Fla.

Freeze-Dried Tissue Homografts; Methods and Clinical Applications in Tissue Banking.
GEORGE W. HYATT, J. W. SAVILLE and J. W. DRAHEIM, Bethesda, Md.
Discussion to be opened by CHALMERS R. CARR, Charlotte, N. C. and I. S. RAVDIN, Philadelphia.

Wednesday, June 13—9 a. m.

BUSINESS MEETING; ELECTION OF OFFICERS

The Value of Lung Biopsy.
CLIFFORD F. STOREY, San Diego, Calif.
Discussion to be opened by J. MAXWELL CHAMBERLAIN, New York, and CLINTON S. LYTER, Denver.

Surgical Resection for Pulmonary Tuberculosis: Results from an Army Thoracic Center.
ELMORE M. ARONSTAM, ROBERT L. ANDERSON, BEN R. LAWTON, and JULIO C. DAVILA, Phoenixville, Pa.
Discussion to be opened by JULIAN JOHNSON, Philadelphia, and CLIFFORD F. STOREY, San Diego, Calif.

Clinical Investigation in Naval Hospitals.
HOWARD T. KARSNER, Washington, D. C.
Discussion to be opened by RICHARD A. KERN, Philadelphia, and PAUL D. DOOLAN, Oakland, Calif.

Report of the Office of the Assistant Secretary of Defense (Health and Medical). FRANK B. BERRY, Washington, D. C.

Myocardial Infarction in a Military Population.
PHILIP G. KEIL, and LEON V. MCVAY JR., Maxwell Air Force Base, Ala.
Discussion to be opened by WILLIAM B. BEAN, Iowa City, and ALPHONSE MCMAHON, St. Louis.

Thursday, June 14—9 a. m.

A Four-Year Follow-Up Study of Frostbite in 100 Military Personnel.
JOSEPH R. BLAIR, RICHARD SCHATZKI, and KENNETH D. ORR, Fort Knox, Ky.
Discussion to be opened by JOHN H. TALBOTT, Buffalo, N. Y. and ALBERT R. BEHNKE JR., San Francisco.

The Impact of Nuclear Weapons on Military and Civilian Medical Organizations.
M. S. WHITE, Langley Air Force Base, Va.
Discussion to be opened by HAROLD C. LUETH, Evanston, Ill., and JAMES P. COONEY, Washington, D. C.

Medical Education for National Defense (MEND).
JAMES R. SCHOFIELD, Washington, D. C.
Discussion to be opened by JOHN B. YOUMANS, Nashville, Tenn., and JOSEPH C. HINSEY, New York.

The Role of the Medical Officer in Military Vehicular Accident Control Programs. GEORGE B. RIBBLE, Cherry Point, N. C.
Discussion to be opened by BARRY G. KING, Washington, D. C., and DON S. WENGER, Washington, D. C.

Acute Respiratory Illness Caused by RI Viruses: A Military Problem. MAURICE R. HILLEMAN, Washington, D. C.

Discussion to be opened by JOHN H. DINGLE, Cleveland, and JOSEPH W. COOCH, Fort Dix, N. J.

SECTION ON MISCELLANEOUS TOPICS

SESSION ON ALLERGY

MEETS IN DRAKE HOTEL, WALTON ROOM

OFFICERS OF SESSION

Co-Chairmen—STANLEY F. HAMPTON, St. Louis, and LAWRENCE J. HALPIN, Cedar Rapids, Iowa.

Secretary—LESTER L. BARTLETT, Pittsburgh.

Thursday, June 14—9 a. m.

Allergy and the Generalist. MAYER A. GREEN, Pittsburgh.

The Management of Allergy: As It Is, As It Might Be.
SAMUEL M. FEINBERG and ALAN R. FEINBERG, Chicago.

The Role of Tranquilizing Drugs in Allergy.
BEN C. EISENBERG, Huntington Park, Calif.

The Allergenicity of Tranquilizing Drugs.
CLARENCE BERNSTEIN and SOLOMON D. KOLTZ, Orlando, Fla.

INTERMISSION

The Use of Prednisone and Prednisolone in the Treatment of Allergic Diseases.
EARL B. BROWN and THOMAS SEIDEMAN, New York.

The Topical Use of Hydrocortisone Hemi-Succinate (Solu-Cortef), Flouro-Hydro-Cortisone (F-Cortef), and Prednisolone (Delta-Cortef) on the Allergic Mucous Membrane: A Controlled Study. WILLIAM C. GRATER, Dallas, Texas.

The Response of Childhood Asthma to Ippb-Aerosol Therapy.
ROY F. GODDARD, Albuquerque, N. Mex.

Question and Answer Period.

SECTION ON NERVOUS AND MENTAL DISEASES

MEETS IN DRAKE HOTEL, BALLROOM

OFFICERS OF SECTION

Chairman—LEE M. EATON, Rochester, Minn.

Vice-Chairman—HENRY W. BROSIN, Pittsburgh.

Secretary—KARL O. VON HAGEN, Los Angeles.

Delegate—HANS H. REESE, Madison, Wis.

Representative to Scientific Exhibit—G. WILSE ROBINSON, Kansas City, Mo.

Executive Committee—A. EARL WALKER, Baltimore, Md.; FRANCIS J. BRACELAND, Hartford, Conn.; DR. EATON; DR. VON HAGEN; and DR. REESE.

Tuesday, June 12—9 a. m.

Mental Illness: A Survey Assessment of Community Rates, Attitudes and Adjustments.
C. H. HARDIN BRANCH, ORLA M. SHAW, and NYLA J. COLE, Salt Lake City.

The Psychiatric Interview as a Tool in Medical Diagnosis.
ROBERT L. FAUCETT, Rochester, Minn.

Discussion to be opened by LEO H. BARTEMEIER, Baltimore, and JACKSON T. SMITH, Omaha.

Electroshock Therapy During the Puerperium.
DAVID J. IMPASTATO and ANTHONY R. GABRIEL, New York.

Discussion to be opened by JOSEPH A. LUHAN, Chicago.

Correlation Between an Anomaly of the Intracellular Metabolism of Adenine Nucleotides and Schizophrenia.
FRANCIS J. GERTY, IVAN BOSZORMENOI-NAGY, and JACQUELINE KUEBER, Chicago.

Discussion to be opened by EDWIN F. GILDEA, St. Louis and HAROLD E. HIMWICH, Galesburg, Ill.

The Therapeutic Process in Electroshock and the Newer Drug Therapies. LEO ALEXANDER, Boston.

Discussion to be opened by LADISLAS J. MEDUNA and JULES H. MASSERMAN, Chicago.

Pharmacological Management of Behavior Disorders of Children
FRANK J. AYD JR., Baltimore.

Discussion to be opened by FREDERIC T. ZIMMERMAN, New York, and HOWARD E. WEATHERLY, Chicago.

Frenquel: Preliminary Observations in Hospital Psychiatry.
SIDNEY V. COHEN and RICHARD R. PARLOUR, Los Angeles.

Discussion to be opened by JOHN T. FERGUSON, Traverse City, Mich.

Wednesday, June 13—9 a. m.

ELECTION OF OFFICERS

Chairman's Address: LEE M. EATON, Rochester, Minn.

Cause of Death in Ruptured Intracranial Aneurysms: A Clinical-Pathological Study.
JOSE BEBIN and ROBERT D. CURRIER, Ann Arbor, Mich.

Discussion to be opened by RUSSELL N. DEJONG, Ann Arbor, Mich.

Treatment of Headache: Pharmacology
ARNOLD P. FRIEDMAN and H. HOUSTON MERRITT, New York.

Discussion to be opened by BENJAMIN BOSHES, Chicago, and ELINOR R. IVES, Los Angeles.

Intracerebral "Hematomas," with Particular Reference to Their Pathogenesis. CYRIL B. COURVILLE, Los Angeles.

Discussion to be opened by CLARK H. MILLIKAN, Rochester, Minn., and BEN W. LICHTENSTEIN, Chicago.

Meralgia Paresthetica. HAROLD STEVENS, Washington, D. C.

Discussion to be opened by FREDERICK P. MOERSCH, Rochester, Minn., and ALEX J. ARIEFF, Chicago.

Some Therapeutic Problems in Diabetes Insipidus Following Intracranial Surgery.
EDWARD C. CLARK, HENRY W. DODGE JR., and RAYMOND V. RANDALL, Rochester, Minn.

Discussion to be opened by ROLAND P. MACKAY and JOSEPH P. EVANS, Chicago.

Thursday, June 14—9 a. m.

The Triceps Reflex. FRANK P. SMITH, Rochester, N. Y.

Discussion to be opened by ERIC OLDBERG, Chicago.

Experience with Cordotomy at the High Cervical Level.
LYLE A. FRENCH, Minneapolis, Minn.

Discussion to be opened by W. JAMES GARDNER, Cleveland.

The Need for Consideration of Intraspinal Tumors as a Cause of Pain and Disability.
WINCHELL MCK. CRAIG, Rochester, Minn.

Discussion to be opened by LOYAL DAVIS, Chicago and EDGAR A. KAHN, Ann Arbor, Mich.

Whiplash Injuries: A Survey of 100 Cases Subsequent to Settlement of Litigation.

NICHOLAS GOTTEN, E. C. SCHULTZ, BLAND CANNON, A. ROY TYRER JR., C. D. HAWKES, DON JOHNSON, FRANCIS MURPHEY, ROBERT RASKIND, and R. E. SEMMES, Memphis, Tenn.

Discussion to be opened by KENNETH H. ABBOTT, Columbus, Ohio and R. GLEN SPURLING, Louisville, Ky.

Carotid Compression in the Neck: Results and Significance in Cases of Carotid Ligation.

E. S. GURDJIAN, J. E. WEBSTER, and FRANCIS A. MARTIN, Detroit.

Discussion to be opened by OSCAR SUGAR and HAROLD C. VORIS, Chicago.

The Management of Intracranial Bleeding.

MAURICE L. SILVER, Providence, R. I.

Discussion to be opened by CARL F. LIST, Grand Rapids, Mich.

The Surgical Treatment of Aneurysms of the Anterior Communicating and Anterior Cerebral Arteries.

CARL H. H. BAUMANN, Memphis, Tenn., and PAUL C. BUCY, Chicago.

Discussion to be opened by RUPERT B. RANEY, Los Angeles, and PAUL C. BUCY, Chicago.

SECTION ON OBSTETRICS AND GYNECOLOGY

MEETS IN DRAKE HOTEL, GOLD COAST ROOM

OFFICERS OF SECTION

Chairman—FRANK R. LOCK, Winston-Salem, N. C.

Vice-Chairman—WOODWARD D. BEACHAM, New Orleans.

Secretary—D. FRANK KALTREIDER, Baltimore.

Delegate—RALPH E. CAMPBELL, Madison, Wis.

Representative to Scientific Exhibit—FREDERICK H. FALLS, River Forest, Ill.

Executive Committee—BERNARD J. HANLEY, Los Angeles; FREDERICK H. FALLS, River Forest, Ill.; DR. LOCK; DR. KALTREIDER; and DR. CAMPBELL.

Tuesday, June 12—2 p. m.

Panel on Breech Presentation

WILLIAM F. MENGERT, Chicago, Moderator.

Etiology and Antenatal Care.

HAROLD S. MORGAN, Lincoln, Neb.

Management of the First Stage of Labor.

ROBERT A. ROSS, Chapel Hill, N. C.

Management of the Second Stage of Labor.

EDWARD C. HUGHES, Syracuse, N. Y.

The Use of Cesarean Section. BERNARD J. HANLEY, Los Angeles.

Wednesday, June 13—2 p. m.

BUSINESS MEETING.

Panel on Sexual Aberration in the Female

WILLARD M. ALLEN, St. Louis, Moderator

Female Pseudohermaphrodism.

HOWARD W. JONES JR., Baltimore.

Intersexuality. JOHN MCL. MORRIS, New Haven, Conn.

Adrenal Hyperplasia. CHARLES W. LLOYD, Syracuse, N. Y.

Types of Steroids Present in Various Virilizing Syndromes.

JAMES T. BRADBURY, Iowa City.

Chairman's Address. FRANK R. LOCK, Winston-Salem, N. C.

Thursday, June 14—2 p. m.

JOINT MEETING WITH SECTION ON UROLOGY IN DRAKE HOTEL, GOLD COAST ROOM

Surgical Injuries of the Ureter and Bladder.

H. HAYNES BAIRD and HOMER R. JUSTIS, Charlotte, N. C.

Discussion to be opened by JOHN G. MASTERSON, Brooklyn, N. Y.

Urinary Incontinence.

ANDREW A. MARCHETTI, Washington, D. C.

Discussion to be opened by HAROLD P. MCDONALD, Atlanta, Ga.

Surgical Renal Lesions Associated with Pregnancy.

W. E. KITTREDGE and R. J. CRAWLEY, New Orleans.

Discussion to be opened by WILLIAM J. DIECKMANN, Chicago.

Pathological Lesions of the Urethra.

LAMAN A. GRAY, Louisville, Ky.

Discussion to be opened by ROGER W. BARNES, Los Angeles; ABEL JAY LEADER, Houston, Texas; and JAMES W. MERRICKS, Chicago.

Question and Answer Period.

SECTION ON OPHTHALMOLOGY

MEETS IN NORTHWESTERN UNIVERSITY, THORNE HALL

OFFICERS OF SECTION

Chairman—ALBERT D. RUEDEMANN SR., Detroit.

Vice-Chairman—JOHN B. HITZ, Milwaukee.

Secretary—HAROLD G. SCHEIE, Philadelphia.

Delegate—WILLIAM L. BENEDICT, Rochester, Minn.

Representative to Scientific Exhibit—FRANK W. NEWELL, Chicago.

Executive Committee—TRYGVE GUNDERSEN, Boston; ERLING W. HANSEN, Minneapolis; DR. RUEDEMANN SR.; DR. SCHEIE; and DR. BENEDICT.

Program of Section on Ophthalmology

Tuesday, June 12—2 p. m.

Chairman's Address: Foveal Coordination: The Major Factor in Visual Learning. A. D. RUEDEMANN SR., Detroit.

Address of Guest of Honor: Ocular Findings Associated with Meningiomas of the Tuberculum Sellae.

FRANCIS C. GRANT, Philadelphia, Guest of Honor, and THOMAS R. HEDGES JR., Philadelphia.

Report of 500 Patients Examined for Low Vision.

GERALD FONDA, Short Hills, N. J.

Discussion to be opened by WILLIAM F. MURRAH, Memphis, Tenn.

Unilateral Internuclear Ophthalmoplegia of Vascular Origin.

MAX FINE and CHARLES B. MACGLASHAN JR., San Francisco.

Discussion to be opened by FRANCIS HEED ADLER, Philadelphia.

Bullous Keratopathy. A. RAY IRVINE JR., Los Angeles.

Discussion to be opened by DAVID G. COGAN, Boston.

Hazards of the Use of Sympathomimetic Drugs in Ophthalmology.

WILLIAM U. MCREYNOLDS, Quincy, Ill.; WILLIAM H. HAVENER, Columbus, Ohio; and JOHN W. HENDERSON, Ann Arbor, Mich.

Discussion to be opened by FREDERICK H. THEODORE, New York.

Tuesday, June 12—8 p. m.

SPECIAL BUSINESS MEETING

Minutes of last meeting.
Old business.
New business.
Public Relations. RALPH O. RYCHENER, Memphis, Tenn.
Distribution Responsibilities of the Specialties Represented in the Scientific Assembly. RALPH H. PINO, Detroit.

Wednesday, June 13—2 p. m.

ELECTION OF OFFICERS

A New Magnetic Orbital Implant.
ORWYN H. ELLIS and O. ROBERT LEVY, Los Angeles.
Discussion to be opened by RICHARD C. TROUTMAN, Brooklyn, N. Y.

Hypersecretion Glaucoma.
BERNARD BECKER, GEORGE R. KELSEY, and ROBERT E. CHRISTENSEN, St. Louis.
Discussion to be opened by W. MORTON GRANT, Boston.

Observations on the Dissimilarity Between the Retinal Capillary Microaneurysm in Diabetes Mellitus and the Nodule of Intercapillary Glomerulosclerosis. DAVID VOLK, Cleveland.
Discussion to be opened by A. EDWARD MAUMANEE, Baltimore.

Pseudostrabismus Caused by Heterotopia Maculae.
HARRY HORWICH, Biloxi, Miss.
Discussion to be opened by HAROLD W. BROWN, New York.

Inflammation of the Retinal Arterioles and Veins With or Without Associated Intraocular Hemorrhages (Eales' Disease).
SAMUEL J. KIMURA, MICHAEL J. HOGAN, and FREDERICK R. CARRIKER, San Francisco.
Discussion to be opened by GEORGIANA THEOBALD, Oak Park, Ill.

A Survey of the Pathogenesis of Retinal Occlusion with Emphasis upon Choice of Therapy, and an Analysis of the Therapeutic Results in Sixty Patients.
BERTHA A. KLIEN, Chicago.
Discussion to be opened by JOHN S. MCGAVIC, Bryn Mawr, Pa.

Thursday, June 14—2 p. m.

The Use of Retrobulbar Air and Laminography in the Localization of Orbital Tumors.
GEORGE R. KESKEY and WILLIAM R. LETSCH, St. Louis.
Discussion to be opened by IRA S. JONES, New York.

Observations on Herpetic Keratitis.
PHILLIPS THYGESON and SAMUEL J. KIMURA, San Francisco.
Discussion to be opened by TRYGVE GUNDERSEN, Boston.

Fungus Keratitis.
T. E. SANDERS and ALBERT P. LEY, St. Louis.
Discussion to be opened by E. R. VEIRS, Temple, Texas.

Vertical Muscle Imbalance and Scoliosis
A. D. RUEDEMANN JR., Detroit.
Discussion to be opened by WILLIAM E. KREWSON, III, Philadelphia.

Pitfalls in Strabismus Surgery.
WALTER H. FINK, Minneapolis.
Discussion to be opened by HERMANN M. BURIAN, Iowa City.

Causes for Retinal Detachment Surgery Failure.
BAYARD H. COLVEAR JR. and DOHRMANN K. PISCHEL, San Francisco.
Discussion to be opened by GRAHAM CLARK, New York.

Association for Research in Ophthalmology

OFFICERS

Chairman—WILLIAM B. CLARK, New Orleans.
Secretary-Treasurer—LORAND V. JOHNSON, Cleveland.

Program of Association for Research in Ophthalmology

Monday, June 11—1 p. m.

MEETS IN KNICKERBOCKER HOTEL, OCEANIC ROOM

Reactions of the Elements of Retina and Optic Nerve in Common Morbid Entities of the Human Eye.
J. REIMER WOLTER, Ann Arbor, Mich.

Observations on the Treatment of a Rabbit Tumor Transplanted Into the Fundus. ADOLPH W. VOGEL, Philadelphia.

Experiments on Woundhealing in the Endothelium of the Cornea.
RUDOLF F. BINDER and HERTHA BINDER, Cleveland.

The Occurrence of Lens Changes Following Irradiation of Single and Multiple Quadrants.
R. D. RICHARDS, EDWARD RILEY, and P. J. LEINFELDER, Iowa City.

The Effect of Moderate Doses of X-Ray Irradiation on Ocular Tissues.
BERNARD BECKER, MARGUERITE A. CONSTANT, PAUL A. CIBIS, MICHEL TER-POGOSSIAN, and ROSALIE SMITH, St. Louis.

Clinical and Experimental Fungus Infections of the Cornea.
ALBERT P. LEY, St. Louis.

A Study of Strains of APC Virus Isolated from Patients with Keratoconjunctivitis.
A. FOWLE, V. SIMMONS, and H. L. ORMSBY, Toronto, Canada.

Observations on Experimental Trachoma and Inclusion Conjunctivitis.
PHILLIPS THYGESON and T. T. CROCKER, San Francisco.

Persistence of Toxoplasma Experimentally Inoculated Into Guinea Pigs' Eyes.
MICHAEL J. HOGAN, PHYLLIS ZWEIGART, and ANN LEWIS, San Francisco.

Ocular Penetration of Antibiotics by Iontophoresis.
S. H. WITZEL, I. FIELDING, and H. L. ORMSBY, Toronto, Canada.

A Comparative Study of Scleral Shortening Operations in Rabbits. WILLIAM G. EVERETT, Pittsburgh.

Tuesday, June 12—8:30 a. m.

The Argyll Robertson Pupillary Syndrome.
OTTO LOWENSTEIN, New York.

Studies on the Autonomic Innervation of the Iris.
JULIA T. APTER, Manteno, Ill.

Some Mechanisms of Centrally Induced Eye Pressure Responses.
LUDWIG VON SALLMANN, FRANK MACRI, THEODOR WANKO, and PATRICIA GRIMES, Bethesda, Md.

Study on the Innervation of the Anterior Chamber Angle.
MONTE HOLLAND, LUDWIG VON SALLMANN, and ELEANOR COLLINS, Bethesda, Md.

The Technique of Determination of Blood Volume Changes in the Choroid and Retina.
J. W. BETTMAN and VICTOR G. FELLOWS, San Francisco.

Cations and the Corneal Stroma.
W. MORTON GRANT, Boston.

Measurements of Aqueous Outflow in Enucleated Eyes.
E. W. PURNELL, C. E. MELTON JR., and E. Q. ADAMS, Cleveland.

Species Variation in Facility of Aqueous Outflow.
BERNARD BECKER and MARGUERITE A. CONSTANT, St. Louis.

Physiological Variations of Bicarbonate Ion Concentration in the Intraocular Fluids.
HARRY GREEN and IRVING H. LEOPOLD, Philadelphia.

Wednesday, June 13—8:30 a. m.

Spectro-Differential Electroretinography in Macular Disease.
JERRY HART JACOBSON and DEMIR BASAR, New York.

The Effect of Hallucinogenic Drugs on the Electroretinogram.
JULIA T. APTER, Manteno, Ill.

Clinical Studies with Flicker Electroretinography.
GILBERT ISER and GEORGE GOODMAN, Bethesda, Md.

The Effect of Rate of Rise of Photic Stimuli on the Human Electroretinogram.
HANS BORNSCHEIN and RALPH D. GUNKEL, Bethesda, Md.

Studies on the Visual Toxicity of Methanol, No. 9: The Effect of Ethanol and Methanol Poisoning on the Rhesus Monkey.
ANITA P. GILGER and ALBERT M. POTTS, Cleveland.

Red and Cone Vision in Retinitis Pigmentosa.
BERNARD H. ZEAVIN and GEORGE WALD, Cambridge, Mass.

Residual Proteins of the Vitreous.
ANITA SURAN and W. K. MCEWEN, San Francisco.

Development of the Orbital Fascia.
WALTER H. FINK, Minneapolis.

Microscopy with a New Illumination Technique.
PAUL A. CIBIS, St. Louis.

Thursday, June 14—8:30 a. m.

A Quantitative Analysis of the Horizontal Movements of the Eyes in the Experiment of Johannes Mueller.
MATHEW ALPERN, Ann Arbor, Mich.

Some Physiological Considerations of Hereditary Macular Degeneration.
RODNEY D. STEINMETZ and KENNETH N. OGLE, Rochester, Minn.

Eye Movements in an Adult with Cerebral Hemispherectomy for Tumor.
DAVID VOLK and JAN H. BRUELL, Cleveland.

Corneal Transport of Lactic Acid as Measured with C-14 Lactate. ALBERT M. POTTS and B. COHEN, Cleveland.

The Hydration of the Cornea: II. The Influence of the Epithelium and Intraocular Pressure.
JOHN E. HARRIS, LETA B. GEHRSITZ, and LOUISE GRUBER, Portland, Ore.

Effect of Castration on Galactose Cataract.
ROBERT A. RESNIK and EUGENE STREICHER, Bethesda, Md.

Enzymatic Activities of Lens: A Preliminary Survey.
BERNARD WORTMAN and BERNARD BECKER, St. Louis.

Effect of Age upon Lens Metabolism.
HARRY GREEN, S. A. SOLOMON, and IRVING M. LEOPOLD, Philadelphia.

Enzyme Systems Concerned with Oxidative Phosphorylation in Ciliary Processes.
ELMER J. BALLINTINE and MORTON B. WAITZMAN, Cleveland.

The Energy Requirements of the Lens: The Ability of Various Metabolites to Replace Glucose as Substrate.
DANIEL J. HEINRICHS and JOHN E. HARRIS, Portland, Ore.

SECTION ON ORTHOPEDIC SURGERY

MEETS IN LAKE SHORE CLUB, BALLROOM

OFFICERS OF SECTION

Chairman—WILLIAM T. GREEN, Boston.
Vice-Chairman—EDWARD L. COMPERE, Chicago.
Secretary—FREDERICK R. THOMPSON, New York.
Acting Secretary—H. HERMAN YOUNG, Rochester, Minn.
Delegate—H. RELTON MCCARROLL, St. Louis.
Representative to Scientific Exhibit—J. VERNON LUCK, Los Angeles.
Executive Committee—CHARLES N. PEASE, Chicago; JESSE T. NICHOLSON, Philadelphia; DR. GREEN; DR. THOMPSON; and DR. MCCARROLL.

Tuesday, June 12—2 p. m.

Metatarsus Primus Varus and Hallux Valgus.
DONALD C. DURMAN, Saginaw, Mich.
Discussion to be opened by JOSEPH L. FLEMING, Detroit, and WALTER FISCHER, Chicago.

Compression Neuropathy of the Median Nerve in the Carpal Tunnel. GEORGE S. PHALEN and J. I. KENDRICK, Cleveland.
Discussion to be opened by ROBERT E. CARROLL, New York, and MICHAEL L. MASON, Chicago.

The Doctor and the Automobile Accident.
MURRAY E. GIBBENS and WILLIAM V. SMITH, Denver.
Discussion to be opened by JACOB KULOWSKI, St. Joseph, Mo., and JOSEPH D. GODFREY, Buffalo, N. Y.

Cineradiography of the Normal Cervical Spine.
J. WILLIAM FIELDING, New York.
Discussion to be opened by BEDFORD F. BOYLSTON, Houston, Texas, and FAY H. SQUIRE, Wheaton, Ill.

Intramedullary Fixation of Pathological Fractures.
EINER W. JOHNSON JR., Rochester, Minn.
Discussion to be opened by J. OTTO LOTTES, St. Louis, and WILLIAM A. LARMON, Chicago.

Foraminotomy and Fusion Following Disk Surgery.
DANA M. STREET, Memphis, Tenn.
Discussion to be opened by H. RELTON MCCARROLL, St. Louis, and FRED FERCIOT, Lincoln, Neb.

Wesdnesday, June 13—2 p. m.

ELECTION OF OFFICERS

The Experimental Use of Hydrocortone in the Traumatized Knees of Rabbits.
CHARLES J. FRANKEL, DAVID K. WEBSTER, and THOMAS HAMILTON, Charlottesville, Va.
Discussion to be opened by HOWARD HATCHER, Chicago, and EARL LEIMBACHER, Joliet, Ill.

Clinical Judgment in Scoliosis.
JOSEPH C. RISSER, Pasadena, Calif.
Discussion to be opened by CHARLES N. PEASE, Chicago, and JOHN H. MOE, Minneapolis.

Chairman's Address. WILLIAM T. GREEN, Boston.

The Effect and Management of Induced Hypoadrenalism on Patients Requiring Orthopedic Surgery.
JAMES A. NICHOLAS, PHILIP D. WILSON, and CHARLES J. UMBERGER, New York.
Discussion to be opened by H. HERMAN YOUNG, Rochester, Minn., and SMITH FREEMAN, Chicago.

Spondylolisthesis: A Review of Eighty-Five Patients Treated by Arthrodesis of the Spine.
GEORGE HAMMOND, Boston.
Discussion to be opened by ROBERT J. JOPLIN, Boston, and FREDERIC C. BOST, San Francisco.

JOINT MEETING WITH THE SECTION ON PHYSICAL MEDICINE IN LAKE SHORE CLUB, BALLROOM

Thursday, June 14—2 p. m.

Fractures in the Aged. CARTER R. ROWE, Boston.
Discussion to be opened by EDGAR M. BICK, New York.

Mental Reaction to Trauma and Hospitalization in the Aged.
EDWARD M. LITEN, Rochester, Minn.
Discussion to be opened by JOHN DONNELLY, Hartford, Conn.

Some Problems with Nutrition in the Aged.
AUSTIN B. CHINN, Cleveland.
Discussion to be opened by ROBERT E. STONE, Birmingham, Ala.

Arthritis in the Aged.
L. MAXWELL LOCKIE and JOHN H. TALBOTT, Buffalo, N. Y.
Discussion to be opened by DONALD F. HILL, Tucson, Ariz.

Physical Medicine in the Aged.
DONALD L. ROSE, Kansas City, Kan.
Discussion to be opened by RALPH E. DEFOREST, Chicago.

SECTION ON PATHOLOGY AND PHYSIOLOGY

MEETS IN DRAKE HOTEL, WALTON ROOM

OFFICERS OF SECTION

Chairman—ROGER D. BAKER, Durham, N. C.
Vice-Chairman—H. RUSSELL FISHER, Pasadena, Calif.
Secretary—EDWIN F. HIRSCH, Chicago.
Delegate—LALL G. MONTGOMERY, Muncie, Ind.
Representative to Scientific Exhibit—FRANK B. QUEEN, Portland, Ore.
Executive Committee—J. EARL THOMAS, Philadelphia; S. A. LEVINSON, Chicago; DR. BAKER; DR. HIRSCH; and DR. MONTGOMERY.

Tuesday, June 12—2 p. m.

Beta-Propiolactone in the Preparation and Sterilization of Vaccines, Tissue Grafts, and Plasma.
FRANK W. HARTMAN and GERALD A. LOGRIPPO, Detroit.
Discussion to be opened by PAUL R. CANNON, Chicago, and FRANK B. QUEEN, Portland, Ore.

Respiratory Disturbances in Acid-Base Balance.
FRED S. GRODINS, Chicago.

Panel Discussion on Functional Disturbances of Respiration in Disorders of the Lung

GEORGE E. WAKERLIN, Chicago, Moderator.

Physiological Consideration. JOHN F. PERKINS, Chicago.

Surgical Consideration. W. E. ADAMS, Chicago.

Pathological Consideration.
JOHN R. MCDONALD, Rochester, Minn.

Medical Consideration. NORMAN B. ROBERG, Chicago.

Plasmocytosis and Cryoglobulinemia in Cancer.
MILTON G. BOHROD, Rochester, N. Y.
Discussion to be opened by JOHN G. KIDD, New York, and MILTON J. STEINHARDT, Detroit.

The Structure and Function of the Nongoitrous Thyroid Gland During Pregnancy.
R. P. STOFFER, I. A. KOENEKE, V. E. CHESKY, and C. A. HELLWIG, Halstead, Kan.
Discussion to be opened by EMMERICH VON HAAM, Columbus, Ohio, and LEO LOWBEER, Tulsa, Okla.

Wednesday, June 13—2 p. m.

BUSINESS MEETING: ELECTION OF OFFICERS.

The Changing Distribution of Helminthic Diseases in the United States.
CARROLL C. L. BIRCH and BASIL PAN ANAST, Chicago.
Discussion to be opened by MARION HOOD, New Orleans, and JOHN BURT FULLER, Chicago.

Neuroblastoma: The Morbid Histology, Clinicopathological Implications and Relationship to Other Tumors of Neural Origin.
DANIEL STOWENS, Washington, D. C.
Discussion to be opened by GEORGE H. FETTERMAN, Pittsburgh, and JAMES B. AREY, Philadelphia.

Chairman's Address: Mucormycosis: A Complication of Diabetes Mellitus, Other Predisposing Diseases, and Modern Therapy: Clinical, Pathological, and Experimental Features.
ROGER D. BAKER, Durham, N. C.

Clinical Applications of the Fractionation of Serum Proteins by Paper Electrophoresis.
F. WILLIAM SUNDERMAN and F. WILLIAM SUNDERMAN JR., Philadelphia.
Discussion to be opened by WILLIAM DOLAN, Arlington, Va., and GEORGE F. STEVENSON, Park Ridge, Ill.

Reactive Lesions of Genitourinary Tract Simulating Neoplasia.
F. K. MOSTOFI and ERICH THEISS, Washington, D. C.
Discussion to be opened by OTTO SAPHIR and HENRY RAPPAPORT, Chicago.

Infantile Hyperplastic and Hypertrophic Cardiomegaly and Endocardial Fibroelastosis. B. BLACK-SCHAFFER, Cincinnati.
Discussion to be opened by JOSEPH D. BOGGS, Chicago.

Thursday, June 14—2 p. m.

JOINT MEETING WITH SECTION ON GASTROENTEROLOGY AND PROCTOLOGY IN UNIVERSITY OF ILLINOIS GYMNASIUM, NAVY PIER

Tropical Sprue: Diagnosis and Treatment.
FRANK H. GARDNER, Boston.

Nontropical Sprue: Diagnosis and Treatment.
MANFRED W. COMFORT and ERIC E. WOLLAEGER, Rochester, Minn.
Discussion to be opened by TOM D. SPIES, Birmingham, Ala.; DAVID ADLERSBERG, New York; GEORGE J. BAYLIN, Durham, N. C.; and JAMES A. HALSTED, Syracuse, N. Y.

Toxic Effects of Chlorpromazine: Hepatitis and Agranulocytosis.
WALLIS L. CRADDOCK, Fort Douglas, Utah.
Discussion to be opened by JOHN R. KELSEY, Houston, Texas, and RICHARD B. CAPPS, Chicago.

The Diagnostic Usefulness of the Alkaline Phosphatase in Nonjaundiced Patients with Hepatobiliary Disease.
THOMAS B. GIBBONS, Seattle.
Discussion to be opened by HARRY SHAY, Philadelphia, and ROBERT M. KARK, Chicago.

Clinico-Pathological Panel Discussion on Acute Conditions in the Upper Abdomen

Internist. FRANK W. JONES, Chicago.

Surgeon. JOHN T. REYNOLDS, Chicago.

Pathologist. EDWIN F. HIRSCH, Chicago.

SECTION ON PEDIATRICS

MEETS IN SHERATON HOTEL, TALLY HO ROOM

OFFICERS OF SECTION

Chairman—F. THOMAS MITCHELL, MEMPHIS, TENN.
Vice-Chairman—ALVAH L. NEWCOMB, Winnetka, Ill.
Secretary—WYMAN C. C. COLE SR., Detroit.
Delegate—WOODRUFF L. CRAWFORD, Rockford, Ill.
Representative to Scientific Exhibit—F. THOMAS MITCHELL, Memphis, Tenn.
Executive Committee—OLIVER L. STRINGFIELD, Stamford, Conn.; WILLIAM WESTON JR., Columbia, S. C.; DR. MITCHELL; DR. COLE; and DR. CRAWFORD.

Tuesday, June 12—9 a. m.

JOINT MEETING WITH SECTION ON PREVENTIVE AND INDUSTRIAL MEDICINE AND PUBLIC HEALTH IN SHERATON HOTEL, TALLY HO ROOM

Symposium on Childhood Poisons

EDWARD PRESS, New York, Moderator.

The Public Health Aspects of Poisoning.
EDWARD PRESS, New York.

Effect and Treatment of Nerve Gas Poisoning in Man.
JOHN R. WOOD, Washington, D. C.

Pharmacological Considerations of Newer Chemicals.
ROBERT GOSSELIN, Rochester, N. Y.

The Manufacturer Looks at Childhood Poisoning.
JOHN H. FOULGER, Wilmington, Del.

Controlling Accidents from Pesticides.
BERNARD CONLEY, Chicago.

Practical Management of Common Poisonings.
JAY M. ARENA, Durham, N. C.

Wednesday, June 13—9 a. m.

BUSINESS MEETING

Chairman's Address. F. THOMAS MITCHELL, Memphis, Tenn.

Pathology Associated with Jaundice in Infancy.
ALBERT M. HAND and EDWIN B. HERRING, Memphis, Tenn.

Cutaneous Moniliasis in Pediatrics: Diagnosis and Treatment with Mycostatin.
BOHDAN DOBIAS, New York.

Migraine in Childhood.
EDMUND C. BURKE and GUSTAVUS A. PETERS, Rochester, Minn.

Modern Infant Feeding. M. G. PETERMAN, Milwaukee.

Repair of Interatrial Septal Defects by the Closed Method.
HARRY GOLDBERG and HOUCK E. BOLTON, Philadelphia.

Direct Relief of Pulmonary Stenosis with Particular Reference to the Tetralogy of Fallot.
DANIEL F. DOWNING, Philadelphia.

Thursday, June 14—9 a. m.

Symposium on the Asthmatic Child

HAROLD S. TUFT, Denver, Moderator.

Development and Course of Asthma in Childhood.
SUSAN C. DEES, Durham, N. C.

The Etiological Diagnosis of Asthma in Childhood.
GEORGE I. BLUMSTEIN, Philadelphia.

The Clinical Diagnosis of Asthma in Childhood.
WILLIAM P. BUFFUM, Providence, R. I.

The Emotional Problems of Childhood and Their Relation to Asthma. HYMAN MILLER, Beverly Hills, Calif.

The Development of the Intractable Asthmatic State and Its Management. HAROLD S. TUFT, Denver.

The Symptomatic Treatment of Asthma in Childhood.
JAMES C. OVERALL, Nashville, Tenn.

SECTION ON PHYSICAL MEDICINE

MEETS IN KNICKERBOCKER HOTEL, OCEANIC ROOM

OFFICERS OF SECTION

Chairman—FRANCES BAKER, San Mateo, Calif.
Vice-Charman—LOUIS B. NEWMAN, Chicago.
Secretary—WALTER J. ZEITER, Cleveland.
Delegate—FRANK H. KRUSEN, Rochester, Minn.
Representative to Scientific Exhibit—DONALD A. COVALT, New York.
Executive Committee—KRISTIAN G. HANSSON, New York; WILLIAM H. SCHMIDT, Philadelphia; DR. BAKER; DR. ZEITER; and DR. KRUSEN.

Tuesday, June 12—2 p. m.

BUSINESS MEETING

Chairman's Address: Application of Exercise in Treatment and Diagnosis. FRANCES BAKER, San Mateo, Calif.

Treatment of Cervicodorsal Outlet Syndrome.
PAUL A. NELSON, Cleveland.
Discussion to be opened by THOMAS P. ANDERSON, Hanover, N. H.

Evaluation of End-Results in Anterior Poliomyelitis.
ROBERT L. BENNETT, Warm Springs, Ga.
Discussion to be opened by NADINE COYNE, Cleveland.

Panel Discussion on Rehabilitation of Patients with Paraplegia

DONALD A. COVALT, New York, Moderator

Rehabilitation Aspects. DONALD A. COVALT, New York.
Neurosurgical Aspects. IRVING S. COOPER, New York.
Orthopedic Aspects. HAROLD A. SOFIELD, Hines, Ill.
Urologic Aspects. HERBERT S. TALBOT, Boston.

Wednesday, June 13—2 p. m.

BUSINESS MEETING: ELECTION OF OFFICERS

Conservative Therapy in Peripheral Nerve Dysfunction.
KEITH C. KEELER, Akron, Ohio.
Discussion to be opened by WILLIAM BIERMAN, New York.

Rehabilitation of the Cardiac Patient.
HERMAN K. HELLERSTEIN, Cleveland.
Discussion to be opened by LOUIS B. NEWMAN, Chicago.

The Present Status of Ultrasound in Medicine.
FRITZ FRIEDLAND, Boston.
Discussion to be opened by JUSTUS F. LEHMANN, Columbus, Ohio.

Panel Discussion on the Chronically Ill

FRANK H. KRUSEN, Rochester, Minn., Moderator.

Rehabilitation Aspects of the Chronically Ill and Aging.
MURRAY B. FERDERBER, Pittsburgh.

Community and Social Aspects. BELL GREVE, Cleveland.

Rehabilitation of the Chronically Ill in the Veterans Administration. A. B. C. KNUDSON, Washington, D. C.

National Aspects. DEAN W. ROBERTS, Chicago.

JOINT MEETING WITH THE SECTION ON ORTHOPEDIC SURGERY IN LAKE SHORE CLUB, BALLROOM

Thursday, June 14—2 p. m.

Fractures in the Aged. CARTER R. ROWE, Boston.
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Mental Reaction to Trauma and Hospitalization in the Aged.
EDWARD M. LITEN, Rochester, Minn.
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Some Problems with Nutrition in the Aged.
AUSTIN B. CHINN, Cleveland.
Discussion to be opened by ROBERT E. STONE, Birmingham, Ala.

Arthritis in the Aged.
L. MAXWELL LOCKIE and JOHN H. TALBOTT, Buffalo, N. Y.
Discussion to be opened by DONALD F. HILL, Tucson, Ariz.

Physical Medicine in the Aged. DONALD L. ROSE, Kansas City.
Discussion to be opened by RALPH E. DEFOREST, Chicago.

SECTION ON PREVENTIVE AND INDUSTRIAL MEDICINE AND PUBLIC HEALTH

MEETS IN CINEMA THEATER, 151 E. CHICAGO AVE.

OFFICERS OF SECTION

Chairman—EDWARD P. LUONGO, Los Angeles.
Vice-Chairman—EDWARD J. TRACY, Dayton, Ohio.
Secretary—FRANK PRINCI, Cincinnati, Ohio.
Delegate—RUTHERFORD T. JOHNSTONE, Los Angeles.
Representative to Scientific Exhibit—PAUL A. DAVIS, Akron, Ohio.
Executive Committee—JEAN S. FELTON, Oak Ridge, Tenn.; JOHN J. PHAIR, Cincinnati; DR. LUONGO; DR. PRINCI; and DR. JOHNSTONE, Los Angeles.

Tuesday, June 12—9 a. m.

JOINT MEETING WITH SECTION ON PEDIATRICS IN SHERATON HOTEL, TALLY HO ROOM

Symposium on Childhood Poisons

EDWARD PRESS, New York, Moderator.

The Public Health Aspects of Poisoning.
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Controlling Accidents from Pesticides.
BERNARD CONLEY, Chicago.

Practical Management of Common Poisonings.
JAY M. ARENA, Durham, N. C.

Wednesday, June 13—2 p. m.

CINEMA THEATER, 151 E. CHICAGO AVE.

BUSINESS MEETING.

Chairman's Address: Health Habits and Heart Disease: A Challenge in Preventive Medicine.
EDWARD P. LUONGO, Los Angeles.

The ABO Blood Group and Disease.
J. A. BUCKWALTER, C. B. WOHLWEND, D. C. COLTER, R. T. TIDRICK, and L. A. KNOWLER, Iowa City.

Pneumoconiosis of Soft Coal Miners in the Ohio Valley, a Clinical Study.
MILTON D. LEVINE and MURRAY B. HUNTER, Bellaire, Ohio.

The Incidence of Lead Poisoning in Children in St. Louis.
BENJAMIN W. LEWIS, St. Louis.

Breathlessness in Coal Miners. JOSEPH MARTIN, Elkins, W. Va.

Occupational Health in the United States Navy and Marine Corps. LLOYD B. SHONE, Washington, D. C.

Radiation: Helpful or Harmful?
MITCHELL R. ZAVON, Cincinnati, Ohio.

Thursday, June 14—2 p. m.

JOINT MEETING WITH ASSOCIATION OF PUBLIC HEALTH PHYSICIANS IN CINEMA THEATER, 151 E. CHICAGO AVE.

Hospital and Medical Facilities Survey and Construction Program. JOHN W. CRONIN, Washington, D. C.

A Statewide Program for Hospitalization of the Indigent.
H. PHILLIP HAMPTON, Tampa, Fla.

Current Report on Poliomyelitis Surveillance.
ALEXANDER D. LANGMUIR, NEIL NATHANSON, and WILLIAM JACKSON HALL, Atlanta, Ga.

Prevention of Psychiatric Illness. PAUL V. LEMKAU, New York.

The Scientific Diagnosis and Treatment of the Community as a Patient. E. G. MCGAVRAN, Chapel Hill, N. C.
Discussion to be opened by HENRY A. HOLLE, Austin, Texas.

SECTION ON RADIOLOGY

MEETS IN LAKE SHORE CLUB, BALLROOM

OFFICERS OF SECTION

Chairman—LEO G. RIGLER, Duarte, Calif.
Vice-Chairman—DONALD S. CHILDS, Syracuse, N. Y.
Secretary—TRAIAN LEUCUTIA, Detroit.
Delegate—BYRL R. KIRKLIN, Rochester, Minn.
Representative to Scientific Exhibit—RICHARD H. CHAMBERLAIN, Philadelphia.
Executive Committee—KENNETH D. A. ALLEN, Denver; LAURENCE L. ROBBINS, Boston; DR. RIGLER; DR. LEUCUTIA; and DR. KIRKLIN.

Tuesday, June 12—9 a. m.

Superficial Spreading Carcinoma of the Stomach: Its Roentgen Diagnosis.
ROBERT S. SHERMAN, New York, and DANIEL WILNER, Atlantic City, N. J.

Primary Malignant Neoplasms of the Duodenum.
SEYMOUR F. OCHSNER and MARTIN S. KLECKNER JR., New Orleans.
Discussion to be opened by IRA H. LOCKWOOD, Kansas City, Mo.

Correlations of Symptoms, Age, Sex, and Habitus with Cholecystographic Findings in 1,000 Consecutive Examinations.
C. L. HINKEL and G. A. MOLLER, Danville, Pa.

Pancreatography: Indications and Observations.
HENRY DOUBILET, M. H. POPPEL, and J. H. MULHOLLAND, New York.

The Use of Radioactive Isotopes in the Evaluation of Gastrointestinal Function.
G. J. BAYLIN, J. K. ISLEY, A. P. SANDERS, R. J. REEVES, J. M. RUFFIN, and W. W. SHINGLETON, Durham, N. C.
Discussion to be opened by HAROLD E. FULTON, Detroit.

Selective Segmental Bronchography.
ANDRE MACKAY, ARMAND TREPANIER, and MAURICE F. DUFRESNE, Montreal, Canada.
Discussion to be opened by LAWRENCE REYNOLDS, Detroit.

Provocative X-Ray Therapy of the Sinuses as a Diagnostic Procedure.
GEORGE COOPER JR. and OSCAR SWINEFORD JR., Charlottesville, Va.

The Present Status of Cobalt-60 Teletherapy in the Management of the Cancer Patient.
GILBERT H. FLETCHER, Houston, Texas.
Discussion to be opened by JAMES W. J. CARPENDER, Chicago.

Wednesday, June 13—9 a. m.

ELECTION OF OFFICERS

Chairman's Address: The Periodic Roentgen Examination: Drudgery or Challenge. LEO G. RIGLER, Duarte, Calif.

Aneurysmal Bone Cysts of the Spine.
CHARLES H. HELMAN, JOHN A. CAMPBELL, and JOHN W. BEELER, Indianapolis.

Evaluation of Osteoporosis by Densitometric Measurements.
ABRAHAM GEFFEN, IRVING FEUER, and JACOB R. DORDICK, New York.
Discussion to be opened by J. GERSHON-COHEN, Philadelphia.

Chordoma: An Uncommon Destructive Lesion of the Cerebrospinal Axis.
CHARLES M. GREENWALD, THOMAS MEANEY, and C. ROBERT HUGHES, Cleveland.
Discussion to be opened by OSCAR A. TURNER, Youngstown, Ohio.

Coarctation of the Aorta in Infants.
RICHARD G. LESTER, ALEXANDER R. MARGULIS, and CHARLES M. NICE JR., Minneapolis.
Discussion to be opened by BERTRAM LEVIN, Chicago.

Buckling of the Aortic Arch Simulating Mediastinal Tumor.
ANDRE J. BRUWER, H. B. BURCHELL, and JOHN R. KIRKLIN, Rochester, Minn.

Pitfalls of Translumbar Aortography.
ELLIOTT C. LASSER and WILLIAM STAUBITZ, Buffalo, N. Y.
Discussion to be opened by EVERETT L. PIRKEY, Louisville, Ky., and WENDELL G. SCOTT, St. Louis.

Thursday, June 14—9 a. m.

JOINT MEETING WITH SECTION ON DISEASES OF THE CHEST IN KNICKERBOCKER HOTEL, BALLROOM

Panel Discussion on Lesions of the Upper Alimentary Tract Producing Chest Symptoms

J. PAUL MEDELMAN, St. Paul, Moderator.

Internist. ARTHUR M. OLSEN, Rochester, Minn.

Radiologists.
CLYDE A. STEVENSON, Spokane, Wash., and LESTER W. PAUL, Minneapolis.

Surgeons.
WILLIAM M. TUTTLE, Detroit, and JOHN MAXWELL CHAMBERLAIN, New York.

Panel Discussion on Abnormalities of the Heart and the Great Vessels.

CONRAD R. LAM, Detroit, Moderator.

Internists.
S. GILBERT BLOUNT JR., Denver, and F. MASON SONES JR., Cleveland.

Radiologists.
CHARLES T. DOTTER, Portland, Ore., and JOHN F. HOLT, Ann Arbor, Mich.

Surgeons.
FRANK L. A. GERBODE, San Francisco, and HENRY T. BAHNSON, Baltimore.

SECTION ON SURGERY, GENERAL AND ABDOMINAL

MEETS IN UNIVERSITY OF ILLINOIS GYMNASIUM, NAVY PIER

OFFICERS OF SECTION

Chairman—WALTMAN WALTERS, Rochester, Minn.
Vice-Chairman—ROBERT E. GROSS, Boston.
Secretary—WALTER G. MADDOCK, Chicago.
Delegate—GROVER C. PENBERTHY, Detroit.
Representative to Scientific Exhibit—JOHN H. MULHOLLAND, New York.
Executive Committee—EMILE F. HOLMAN, San Francisco; ROBERT M. ZOLLINGER, Columbus, Ohio; DR. WALTERS; DR. MADDOCK; and DR. PENBERTHY.

Tuesday, June 12—9 a. m.

Diagnosis and Treatment of Thyroiditis.
JAMES W. HENDRICK, San Antonio, Texas.
Discussion to be opened by GEORGE CRILE JR., Cleveland, and HARLAN J. SPJUT, St. Louis.

Substernal Goiter: Differential Diagnosis, Pathology, and Treatment. GUSTAF E. LINDSKOG, New Haven, Conn.
Discussion to be opened by J. HARVEY JOHNSTON JR., Jackson, Miss., and THOMAS H. BURFORD, St. Louis.

Personal Technique and Results in Inguinal Hernia Repair.
AMOS R. KOONTZ, Baltimore.
Discussion to be opened by LAWRENCE S. FALLIS, Detroit, and MERLE M. MUSSELMAN, Omaha.

The Present Status of Subtotal Gastrectomy With and Without Vagotomy in Duodenal and Gastrojejunal Ulcer.
RALPH COLP, New York.
Discussion to be opened by REGINALD H. SMITHWICK, Boston, and JOHN M. BEAL, New York.

Treatment of the High-Lying Gastric Ulcer.
R. K. GILCHRIST, Chicago.

The Surgeon Retires ALLEN O. WHIPPLE, New York.

Wednesday, June 13—9 a. m.

ELECTION OF OFFICERS

Chairman's Address: Suitable Controls in Surgical Investigations.
WALTMAN WALTERS, Rochester, Minn.

Psychosomatic Aspects of Surgery.
BARTHOLOMEW W. HOGAN, Washington, D. C.

The Results of Sphincter Preserving Operations for Carcinoma of the Midrectum.
R. RUSSELL BEST and JOHN A. RASMUSSEN, Omaha.
Discussion to be opened by JOHN M. WAUGH, Rochester, Minn., and WALTER G. MADDOCK, Chicago.

The Immediate Management of the Injured Ureter.
VINCENT J. O'CONOR, Chicago.
Discussion to be opened by HARRY M. SPENCE, Dallas, Texas, and CHARLES C. HIGGINS, Cleveland.

Progress in the Surgical Management of Aortic Aneurysms.
MICHAEL E. DE BAKEY, DENTON A. COOLEY, and OSCAR CREECH JR., Houston, Texas.
Discussion to be opened by DAVID P. BOYD, Boston, and CONRAD R. LAM, Detroit.

Present Concepts in the Surgical Treatment of Esophageal Hiatus Hernia.
JOHN W. KIRKLIN, O. T. CLAGETT, T. T. MYRE, and HOWARD A. ANDERSON, Rochester, Minn.
Discussion to be opened by ROBERT WOODRUFF, Denver, and J. S. BATTERSBY, Indianapolis.

Thursday, June 14—9 a. m.

Practical Aspects of the Surgical Treatment of Breast Cancer.
EDWARD F. LEWISON, Baltimore.
Discussion to be opened by ROBERT T. TIDRICK, Iowa City, and FRANK F. ALLBRITTEN JR., Kansas City, Mo.

The Results and Technique of Stripping Operation for Varicose Veins. THOMAS T. MYERS, Rochester, Minn.
Discussion to be opened by JOHN H. OLWIN and ORMAND C. JULIAN, Chicago.

Obscure and Delayed Causes of Intra-Abdominal Hemorrhage from Trauma.
W. A. ALTEMEIER, ROGER T. SHERMAN, and C. THOMAS FULTZ, Rochester, Minn.
Discussion to be opened by AMBROSE H. STORCK, New Orleans, and JOHN M. HOWARD, Atlanta, Ga.

Panel Discussion on Common Duct Stones

WALTMAN WALTERS, Rochester, Minn., Moderator.

The Practical Value of Operative Cholangiography.
C. ALLEN WALL and S. PATRICK PEARTREE, St. Louis.

The Problem of Retained and Recurrent Common Duct Stones.
WILLIAM P. LONGMIRE JR., SETH W. SMITH, CHARLES E. ENGEL, and BERYL D. AVERBROOK, Los Angeles.

Disappearance of "Stone" Shadows in Postoperative Cholangiograms.
WARREN H. COLE and WILLIAM H. HARRIDGE, Chicago.

Additional Collaborators: CHARLES G. JOHNSTON, Detroit, HENRY K. RANSOM, Ann Arbor, Mich., and T. HOWARD CLARKE, Chicago.

SECTION ON UROLOGY

MEETS IN DRAKE HOTEL, BALLROOM

OFFICERS OF THE SECTION

Chairman—RUBIN H. FLOCKS, Iowa City.
Vice-Chairman—ROGER W. BARNES, Los Angeles.
Secretary—THOMAS A. MORRISSEY, New York.
Delegate—JAY J. CRANE, Los Angeles.
Representative to Scientific Exhibit—MILTON M. COPLAN, Miami, Fla.
Executive Committee—EARL E. EWERT, Boston; CHARLES C. HIGGINS, Cleveland; DR. FLOCKS; DR. MORRISSEY; and DR. CRANE.

Tuesday, June 12—2 p. m.

Prevention of Osteitis Pubes and Hemostasis in Retropubic Prostatectomy. O. A. NELSON, Seattle.
Discussion to be opened by FRANCIS A. BENEVENTI, New York.

Renal Biopsy. ROBERT LICH JR., Lousiville.
Discussion to be opened by WILLIAM L. VALK, Kansas City, Kan.

The Treatment of Undescended Testes.
JAMES C. KIMBROUGH and JOSIAH F. REED, Washington, D. C.
Discussion to be opened by WILLIAM J. BAKER, Chicago.

The Mechanism of Inflammation as Related to Surgical Management and General Resistance.
WILLIAM P. HERBST JR., Washington, D. C.
Discussion to be opened by MATTHEW TAUBENHAUS, Chicago.

Salicylate Therapy for Recurrent Calcium-Containing Calculi.
BURNHAM S. WALKER and EDWIN L. PRIEN, Brookline, Mass.
Discussion to be opened by RALPH R. LANDES, Danville, Va.

Vesicointestinal Fistula.
BENJAMIN S. ABESHOUSE, MARTIN A. ROBBINS, and MARK E. GANN, Baltimore.
Discussion to be opened by CHARLES C. HIGGINS, Cleveland; WILLIAM A. MILNER, Albany, N. Y.; and GEORGE H. EWELL, Madison, Wis.

Primary Tumors of the Ureter.
FRANCIS PATTON TWINEM, New York.

Wednesday, June 13—2 p. m.

ELECTION OF OFFICERS

Chairman's Address: Progress Report in the Use of Radio-Isotopes in Prostatic Carcinoma.
RUBIN H. FLOCKS, Iowa City.

The Use of Chlorpactin in the Treatment of Interstitial Cystitis.
J. KENNETH SOKOL and GEORGE J. BULKLEY, Chicago.
Discussion to be opened by ARTHUR T. WILLETTS, Summit, N. J.

Cystic Disorders of the Kidney: Classification, Diagnosis, and Treatment.
HARRY M. SPENCE, SYDNEY S. BAIRD, and ELGIN W. WARE JR., Dallas, Texas.
Discussion to be opened by CHARLES A. HULSE, San Antonio, Texas; DAVID W. GODDARD, Daytona Beach, Fla.; and JOHN M. TUDOR JR., Nashville, Tenn.

Urinary Steroids and Prognosis in Prostatic Carcinoma.
FREDERICK B. BURT and WILLIAM W. SCOTT, Baltimore.
Discussion to be opened by CHARLES B. HUGGINS, Chicago.

Endocrine Therapy of Prostatic Carcinoma.
EDWARD H. RAY and PETER VAN DOOREN, Lexington, Ky.
Discussion to be opened by FREDERICK W. SCHACHT, Evanston, Ill.

The Results of Simple Perineal Prostatectomy.
RODERICK T. TURNER and ELMER BELT, Los Angeles.
Discussion to be opened by ALBERT E. GOLDSTEIN, Baltimore.

Ureterocutaneous Anastomosis Without the Use of Catheters.
NORRIS J. HECKEL and JAMES H. MCDONALD, Chicago.
Discussion to be opened by MYRON H. NOURSE, Indianapolis.

Thursday, June 14—2 p. m.

JOINT MEETING WITH SECTION ON OBSTETRICS AND GYNECOLOGY IN DRAKE HOTEL, GOLD COAST ROOM

Surgical Injuries of the Ureter and Bladder.
H. HAYNES BAIRD and HOMER R. JUSTIS, Charlotte, N. C.
Discussion to be opened by JOHN G. MASTERSON, Brooklyn, N. Y.

Urinary Incontinence.
ANDREW A. MARCHETTI, Washington, D. C.
Discussion to be opened by HAROLD P. MCDONALD, Atlanta, Ga.

Surgical Renal Lesions Associated with Pregnancy.
W. E. KITTREDGE and R. J. CRAWLEY, New Orleans.
Discussion to be opened by WILLIAM J. DIECKMANN, Chicago.

Pathological Lesions of the Urethra.
LAMAN A. GRAY, Louisville, Ky.
Discussion to be opened by ROGER W. BARNES, Los Angeles, ABEL JAY LEADER, Houston, Texas, and JAMES W. MERRICKS, Chicago.

Question and Answer Period.

COLOR TELEVISION

NAVY PIER, ROOM B

The program has been prepared by the following local committee on television:

WARREN H. COLE, Chairman
JOHN T. REYNOLDS, Co-Chairman

The telecasts, sponsored and produced by Smith, Kline & French Laboratories of Philadelphia, will originate from the University of Illinois Research and Educational Hospitals. For the first time at an Annual Meeting, a moderator will be present with the audience at Navy Pier to provide two-way communication between the audience, the operating surgeon, and a panel of experts at the hospital.

Monday, June 11—2 p. m.

A Day in the Life of a Premature Infant.
HEYWORTH N. SANFORD, HELEN MACK, EVELYN FERU, and MORTON B. ANDELMAN, Chicago.

Cardiac Emergencies.
NORMAN B. ROBERG, LOUIS H. FELDMAN, FORD K. HICK, and MARK H. LEPPER, Chicago.

Abnormal Growth in Children.
I. PAT BRONSTEIN, I. M. ROSENTHAL, J. S. HYDE, and THEODORE SCHWARTZ, Chicago.

The Care of Respiratory Paralysis.
MARK H. LEPPER, GEORGE A. SAXTON JR., JANET WOLTER, and NORMAN B. ROBERG, Chicago.

Tuesday, June 12—9 a. m.

Repair of Intracardiac Septal Defect.
ORMAND C. JULIAN, EGBERT H. FELL, CARL B. DAVIS JR., Chicago, HENRY SWAN, Denver, and CONRAD R. LAM, Detroit.

Pneumonectomy for Carcinoma of the Lung.
WILLARD VAN HAZEL, ROBERT J. JENSIK, and EDWARD JAMES BEATTIE JR., Chicago.

Tuesday, June 12—2 p. m.

Technique of Skin Testing in Allergy.
MAX SAMTER and RAY F. BEERS JR., Chicago.

Use and Abuse of Physical Medicine.
DAVID I. ABRAMSON, ALVIN J. HARRIS, MIRIAM J. PARTRIDGE, and EDWARD E. GORDON, Chicago.

Spina Bifida.
ERIC OLDBERG, BEN W. LICHTENSTEIN, PAUL W. GREELEY, and OSCAR SUGAR, Chicago.

Psychiatry and General Practice.
PAUL E. NIELSON, JOHN W. HANNI, PATRICK ISRAEL, DAVID E. CHEIFETZ, and JOEL HANDLER, Chicago.

Wednesday, June 13—9 a. m.

Abdominal Hysterectomy.
VINCENT CHARLES FREDA, HERBERT E. SCHMITZ, JOHN I. BREWER, and EDWIN J. DE COSTA, Chicago.

Surgical Biopsies: Breast—Lymph Node—Cervix.
DANELY P. SLAUGHTER, HARRY W. SOUTHWICK, and VINCENT CHARLES FREDA, Chicago.

Wednesday, June 13—2 p. m.

Forceps Delivery.
WILLIAM F. MENGERT, DAVID N. DANFORTH, AUGUSTA WEBSTER, M. EDWARD DAVIS, Chicago.

The Problem of the Injured Hip.
CLAUDE N. LAMBERT, Chicago, WALTER BLOUNT, Milwaukee, GEORGE J. GARCEAU, Indianapolis, and HAROLD SOFIELD, Oak Park, Ill.

Examination of the Back: Diagnosis and Treatment.
CLAUDE N. LAMBERT, SAM W. BANKS, Chicago, LEE FORD, and FRED REYNOLDS, St. Louis.

Dermatology in General Practice.
SIDNEY BARSKY, SAMUEL W. BECKER JR., ADOLPH ROSTENBERG JR., HAROLD SHELLOW, ALBERT H. SLEPYAN, and MARCUS R. CARO, Chicago.

Thursday, June 14—9 a. m.

Repair of Femoral and Inguinal Hernias.
WILLIAM J. GROVE, DWIGHT E. CLARK, JOHN T. REYNOLDS, Chicago, and LAWRENCE S. FALLIS, Detroit.

Rectal Surgery, Hemorrhoidectomy, Fissurectomy, Excision Fistula in Ano.
JOHN T. REYNOLDS, GUY V. PONTIUS, Chicago, and J. PEERMAN NESSELROD, Evanston, Ill.

Thursday, June 14—2 p. m.

The Obligation of the General Practitioner to Detect Glaucoma.
WILLIAM F. HUGHES JR., PETER C. KRONFELD, HOWARD L. WILDER, EDWARD A. PUSHKIN, JOSEPH S. HAAS, Chicago, and H. ISABELLE MCGARRY, Evanston, Ill.

The Hard of Hearing Child: Diagnosis, Treatment, and Rehabilitation.
RICHARD A. BUCKINGHAM, CATHERINE LEE CUBERT, CHARLES M. LIGHTFOOT, JOHN MCCAULEY, and FRANCIS L. LEDERER, Chicago.

Hoarseness, Clinical Significance.
PAUL H. HOLINGER, KENNETH C. JOHNSTON, LINDEN J. WALLNER, RICHARD A. BUCKINGHAM, and FRANCIS L. LEDERER, Chicago.

Recovery Room.
MAX S. SADOVE and JAMES H. CROSS, Chicago.

MOTION PICTURE PROGRAM

Monday to Thursday, June 11-14

NAVY PIER, ROOM A

The Action of the Human Heart Valves.
KARL P. KLASSEN and CHARLES V. MECKSTROTH, Columbus, Ohio.

Anomalies of the Aortic Arch.
GEORGE HUMPHREYS II, New York.

Appendectomy.
PHILIP THOREK, Chicago.

Automobile Accident Fractures of the Larynx.
PAUL H. HOLINGER, Chicago.

Carcinoma of the Stomach.
ALTON OCHSNER, New Orleans.

The Action of N-Allylnormorphine Before Birth.
FRANKLIN F. SNYDER, Boston.

Embryology and Pathology of the Intestinal Tract.
LAWRENCE CHAFFIN, Los Angeles.

Fractional Lumbar Epidural Analgesia.
LE ROY W. KRUMPERMAN, Philadelphia.

Grand Rounds: Diagnosis and Management of Acute Abdominal Problems.
GEORGE DANA, Boston, Moderator.

The Inguinal Canal and Scrotal Contents.
JOSEPH E. MARKEE, Durham, N. C.

Liver Biopsy with the Vim Silverman Needle.
CHARLES H. BROWN, Cleveland.

Manual Rotation in the Management of Occiput Posterior and Occiput Transverse Positions.
H. J. HOLLOWAY,* Chicago.

The Motion Picture in Medical Education.
American Medical Association, Chicago.

Myasthenia Gravis: Diagnosis, Treatment, and Management.
KERMIT E. OSSERMAN, New York.

A New Approach to Carbonic Anhydrase Inhibition: (Diamox) Acetazolamide.
CHRISTOPHER H. DEMOS, Pearl River, N. Y.

New Technique of Bronchoscopy.
J. M. DU BOIS DE MONTREYNAUD, Reims, Marne, France.

Operative Cholangiography.
PHILIP F. PARTINGTON and MAURICE D. SACHS, Cleveland.

Operative Clinic on Jaundice.
FRANCIS D. MOORE, Boston.

The Patient Is a Person.
SAMUEL FOGELSON, Chicago.

Pitfalls in the Management of Refractory Heart Failure.
HAROLD JEGHERS, W. PROCTOR HARVEY, JACK SEGAL, FRANKLIN BERKMAN, and DONALD SCHILDER, Washington, D. C.

Posterior Herniation of Lumbar Intervertebral Disks.
O. SCAGLIETTI, Firenze, Italy.

* Deceased.

Prefabricated Casts.
LEON O. PARKER and WILLIAM E. JENSEN, San Francisco.

Radical Neck Dissection Through Transverse Incisions.
WILLIAM F. MACFEE, New York.

Resection of Abdominal Aorta and Replacement with Graft.
H. REICHARD KAHLE, New Orleans.

Resuscitation for Cardiac Arrest.
CLAUDE S. BECK, Cleveland.

Still Going Places: Active Management of Disability in the Aged.
FREDERIC D. ZEMAN and LEO DOBRIN, New York.

Surgical Treatment of Dissecting Aneurysm of the Aorta.
MICHAEL E. DEBAKEY, Houston.

Symposium on Vascular Head Pain.
DEREK DENNY-BROWN, Boston, Moderator.

Surgical Treatment of Urethral Diverticulum in the Female.
JAMES W. MERRICKS, ERNEST M. SOLOMON, LOWELL F. PETERSON, and FRANK PAPIERNIAK, Chicago.

The Technique of Proctosigmoidoscopy and Its Role in the Cancer Detection Program.
WILLIAM C. BERNSTEIN, St. Paul.

Technique of Tonsillectomy and Adenoidectomy.
LINDEN J. WALLNER, Chicago.

The Termination of the Bile Duct.
JULIAN A. STERLING, Philadelphia.

Thiersch's Operation for Anal Incontinence and Minor Degrees of Rectal Prolapse.
VINCENT A. CIANCI, Providence, R. I.

Total Right Hepatic Lobectomy.
GEORGE T. PACK and RICHARD D. BRASFIELD, New York.

Use of Nitrous Oxide Oxygen Analgesia and Anectine for Major Cardiac Surgery.
SEYMOUR SCHOTZ, Philadelphia.

The Value of Succinylcholine Chloride in Electroconvulsive Therapy and Laryngospasm.
GEORGE THOMAS, Pittsburgh.

SPECIAL EVENING MOTION PICTURE PROGRAM

SHERATON HOTEL, GRAND BALLROOM

Wednesday, June 13—8 p. m.

Symposium on Diseases of the Gallbladder and Common Duct

WARREN H. COLE, Chicago, Moderator.

Acute Cholecystitis.
FRANK GLENN, New York Hospital, New York.

Technique for Cholecystectomy with Common Duct Exploration.
RICHARD B. CATTELL, the Lahey Clinic, Boston.

Precautions in Cholecystectomy.
WARREN H. COLE, University of Illinois College of Medicine, Chicago.

Operative and Postoperative Cholangiography.
JOHN M. WAUGH, Mayo Clinic, Rochester, Minn.

The authors will introduce their films and will answer questions from the audience.

THE SCIENTIFIC EXHIBIT

The Scientific Exhibit will be located on Navy Pier, on the east end of the upper level of North Pier.

The 21 sections of the Scientific Assembly have arranged groups of exhibits as in former years, dealing with the respective specialties. Emphasis will be placed on broad aspects of the subjects shown, however, rather than on specialized aspects, so that all exhibits will be of general interest. Special features include an exhibit on pulmonary function testing by the Section on Diseases of the Chest, physical examinations for physicians under the auspices of the Section on General Practice, an exhibit on fresh tissue pathology by the Section on Pathology and Physiology, and general discussions of the urology exhibits at designated hours by the Section on Urology.

Other features arranged by the Council on Scientific Assembly include the special exhibit on fractures, special exhibit on cardiovascular diseases, exhibit symposiums on traffic accidents and on arthritis, question and answer conferences on cardiovascular diseases and on diabetes, and two prize-winning exhibits selected from the National Science Fair.

The Scientific Exhibit will open at 8:30 a. m., Monday, June 11, and will close at 12:00 noon, Friday, June 15. On the intervening days the Pier will be open from 8:30 a. m. to 5:30 p. m.

Admission to the Scientific Exhibit will be limited to those persons wearing one of the official badges of the Convention, with the exception that on Wednesday and Thursday mornings, *guests of physicians* will not be admitted. At that time, only physicians wearing a physician's badge will be admitted to the Pier.

Science Fair Exhibits

The Council on Scientific Assembly has arranged for the presentation of two exhibits selected from the National Science Fair in Oklahoma City, in May, to be shown in the Scientific Exhibit of the American Medical Association. The two high school students who have the best exhibits in the field of biology or medicine will accompany their exhibits and will demonstrate them during the meeting.

Special Exhibit on Fractures

The Special Exhibit on Fractures is presented under the auspices of the following Committee:

RALPH G. CAROTHERS, Cincinnati, Chairman.
HARRY B. HALL, Minneapolis.
CHARLES V. HECK, Chicago.

Demonstrations will be conducted simultaneously each morning and afternoon during the meeting in each of five booths on the following subjects:

Fractures of the Ankle.

Traction for Upper and Lower Extremities.

Fractures Resulting from a Fall on the Outstretched Hand.

Supracondylar Fractures of the Humerus.

Fractures Encountered by the Front Seat Passenger in an Automobile Crash.

The demonstrations will deal with basic principles for the interest of the physician in general practice. A pamphlet presenting the essential features of the exhibit will be available for distribution.

The following demonstrators will assist the Committee in the presentation of the exhibit:

RICHARD J. BENNETT JR., Chicago.
DON N. BERNING, Cincinnati.
JOHN L. BIANCHI, Worcester, Mass.
ROY E. BRACKIN, Winnetka, Ill.
HERBERT L. BRUMBAUGH, Dayton, Ohio.
F. PAUL DUFFY, Cincinnati.
WILLIAM MCDANIEL EWING, Louisville, Ky.
NICHOLAS J. GIANNESTRAS, Cincinnati.
EARL HARTER, Pittsburgh.
CHARLES U. HAUSER, Hamilton, Ohio.
WILLIAM J. KISIEL, Springfield, Mass.
JOSEPH C. LAWRENCE, Evansville, Ind.
RALPH T. LIDGE, Chicago.
WALTER T. LUDLUM JR., New York.
SYDNEY N. LYTTLE, Flint, Mich.
ANDREW R. MAILER, Madison, Wis.
FRANK G. MURPHY, Chicago.
THEODORE NORLEY, Columbia, S. C.
FRANK G. OBER, Burlington, Iowa.
EDMUND T. RUMBLE JR., Callicoon, N. Y.
OTTO SALSBERY, Covington, Ky.
HARLEY M. SIGMOND, Evanston, Ill.
GARLAND F. SMITH, St. Louis.
HAROLD E. SNEDDEN, Sandusky, Ohio.
BARBARA B. STIMSON, Poughkeepsie, N. Y.
FRED L. STUTTLE, Peoria, Ill.
EDGAR H. WHITE, Cincinnati.

Cardiovascular Demonstrations

Demonstrations and talks on Cardiovascular Disease have been arranged by the following Committee:

GEORGE E. BURCH, New Orleans, Chairman.
C. THORPE RAY, New Orleans.
S. GILBERT BLOUNT JR., Denver.

Demonstrations will be presented in the Scientific Exhibit beginning Monday afternoon from 2 to 4 p. m. and from 10 a. m. to 12 noon and 2 to 4 p. m. on Tuesday, Wednesday and Thursday, while talks and discussions will be presented on a definite schedule in an adjoining room. Demonstrations are scheduled as follows:

Monday, June 11

2:00 p. m. **Cardiovascular Surgery.**
MICHAEL E. DE BAKEY, DENTON A. COOLEY, and OSCAR CREECH JR., Houston, Texas.

Tuesday, June 12

10:00 a. m. and 2:00 p. m. **Kidney.** ROBERT M. KARK, Chicago.

Wednesday, June 13

10:00 a. m. and 2:00 p. m. **Congenital Heart Disease.**
S. GILBERT BLOUNT JR., Denver

Thursday, June 14

10:00 a. m. and 2:00 p. m. **Pathology of the Heart.**
OTTO SAPHIR, CONRAD L. PIRANI, Chicago, and GRANT C. JOHNSON, Springfield, Ill.

Cardiovascular Conferences

Each morning from 9 to 10 a. m., physicians may bring electrocardiograms of their patients for interpretation and discussion. The program follows:

Monday, June 11

4:00 p. m. **Therapeutic Conference on Angina.**
GEORGE E. BURCH and C. THORPE RAY, New Orleans.

Tuesday, June 12

9:00 a. m. **Problems and Interpretations in ECG.**
GEORGE E. BURCH, New Orleans.

10:00 a. m. **Practical Aspects of Cardiac Auscultation and Fluoroscopy.**
J. SCOTT BUTTERWORTH, New York.

11:00 a. m. **Questions and Answers on Cardiac Irregularities.**
C. THORPE RAY, New Orleans.

4:00 p. m. **Therapeutic Conference on Congestive Heart Failure.** GEORGE E. BURCH, New Orleans.

Wednesday, June 13

9:00 a. m. **Problems and Interpretations in ECG.**
C. THORPE RAY, New Orleans.

10:00 a. m. **Practical Aspects of Cardiac Auscultation and Fluoroscopy.**
J. SCOTT BUTTERWORTH, New York.

11:00 a. m. **Questions and Answers on Diuretics.**
GEORGE E. BURCH and EMANUEL H. BRESLER, New Orleans.

4:00 p. m. **Therapeutic Conference on Hypertension.**
EDWARD D. FREIS, Washington, D. C.

Thursday, June 14

9:00 a. m. **Problems and Interpretations in ECG.**
EUGENE LEPESCHKIN, Burlington, Vt.

10:00 a. m. **Practical Aspects of Cardiac Auscultation and Fluoroscopy.**
J. SCOTT BUTTERWORTH, New York.

11:00 a. m. **Questions and Answers on Low Salt Syndrome.**
ROBERT M. KARK, Chicago, and ELLIOT NEWMAN, Nashville, Tenn.

4:00 p. m. **Therapeutic Conference on Coronary Occlusion.**
EUGENE LEPESCHKIN, Burlington, Vt., and ELLIOT NEWMAN, Nashville, Tenn.

Friday, June 15

9:00 a. m. **Problems and Interpretations in ECG.**
RICHARD LANGENDORF and ALFRED PICK, Chicago.

10:00 a. m. **Practical Aspects of Cardiac Auscultation and Fluoroscopy.**
J. SCOTT BUTTERWORTH, New York.

11:00 a. m. **Questions and Answers on Diets in Heart Disease.**
RUTH PICK and JEREMIAH STAMLER, Chicago.

Diabetes Exhibits

The diabetes program, including the exhibits and the question and answer conferences, has been arranged under the chairmanship of HOWARD F. ROOT, Boston. Descriptions of the exhibits follow:

Diabetes Today.
HOWARD F. ROOT, ELLIOTT P. JOSLIN, PRISCILLA WHITE, ALEXANDER MARBLE, ALLEN P. JOSLIN, ROBERT F. BRADLEY, and LEO P. KRALL, Joslin Clinic, Boston.

Complications Associated with Diabetes Mellitus.
WILLIAM R. KIRTLEY, Indianapolis, and HENRY T. RICKETTS, Chicago, American Diabetes Association.

Diabetes Conferences

A series of diabetes conferences, intended to serve as question and answer periods, will begin on Monday, June 11 at 10:00 a. m. and will be held each day through Friday noon. The subjects will include:

The New Oral Antidiabetic Sulfonamides.
Treatment of Acidosis and Coma.
Problems in Pregnancy Occurring in Young Diabetic Women of Long Duration.
Childhood Diabetes after Twenty Years.
Management of Diabetes During Surgical Complications.
Treatment of Hypoglycemia.
Insulin-Resistance.
Management of the Brittle Diabetic.
The Use of the Newer Insulins.
Problems in Vascular Disease.

At 12 noon each day, except Friday, a panel discussion will be presented, dealing with the new sulfonamides, complications in treatment, and the problem of diabetic control.

Exhibit Symposium on Traffic Accidents

A group of exhibits on traffic accidents has been arranged to supplement the Symposium on Traffic Accidents in the General Scientific Meeting on Friday morning in cooperation with the Committee on Medical Aspects of Automobile Injuries and Deaths, American Medical Association.

Auto Crash Injury Research.
E. C. PAUL, Indiana State Police, Indianapolis.

What Is a Safe Driver?
FREDERICK L. MCGUIRE, Naval Medical Field Research Laboratory, Camp Lejeune, N. C.

The Physician's Responsibility in the Prevention of Traffic Accidents.
CARY N. MOON JR., FLETCHER D. WOODWARD, and EDWARD L. COREY, University of Virginia School of Medicine, Charlottesville, Va.

Clinical Aspects of Automobile Accidents.
JACOB KULOWSKI, St. Joseph, Mo.

Treatment of Traffic Injuries.
CLAIRE L. STRAITH, RICHARD E. STRAITH, JOSEPH D. CARLISLE, and BURNS G. NEWBY, the Straith Memorial Hospital, Detroit.

Automotive Crash Injury Research.
JOHN J. KELLEY and JOHN O. MOORE, Automotive Crash Injury Research, Cornell University Medical College, New York.

Tests for Intoxication.
HERMAN A. HEISE, Milwaukee, Committee on Medicolegal Problems, American Medical Association.

Repair of Facial Deformities and Internal Wiring of Fractured Jaws.
JAMES BARRETT BROWN and MINOT P. FRYER, Washington University School of Medicine, St. Louis.

Exhibit Symposium on Arthritis and Rheumatism

The exhibit symposium on arthritis and rheumatism has been arranged in cooperation with members of the American Rheumatism Association and the Arthritis and Rheumatism Foundation. A consultation booth, sponsored by the Arthritis and Rheumatism Foundation, will be available where physicians may discuss problems regarding their patients who have arthritis. Consultants who are members of the American Rheumatism Association will be on duty each day.

Gout.

L. MAXWELL LOCKIE and JOHN H. TALBOTT, University of Buffalo School of Medicine and Buffalo General Hospital, Buffalo.

Painful Shoulder Syndromes.

OTTO STEINBROCKER, SIDNEY BERKOWITZ, MORTIMER EHRLICH, and MARVIN CHIRLS, Hospital for Joint Diseases and Lenox Hill Hospital, New York.

Paget's Disease, an Example of a Disease with Which Arthritis Is Frequently Associated.

EDWARD F. HARTUNG, New York University Postgraduate Medical School, New York.

Hydrocortisone: Intra-Articular Therapy.

IRVING L. SPERLING, Newark, N. J.

The Significance of Laboratory Data in the Collagen Disorders.

WILLIAM K. ISHMAEL, RICHARD W. PAYNE, MARVIN R. SHETLAR, J. N. OWENS, and MARY L. DUFFY, McBride Clinic, University of Oklahoma School of Medicine, Oklahoma City.

Sjogren's Syndrome: A Study of Nine Cases.

CHARLES W. DENKO, University of Chicago, the School of Medicine, Chicago, and DELBERT M. BERGENSTAL, National Cancer Institute, National Institutes of Health, Bethesda, Md.

Prednisone and Rheumatism.

CARL A. BERNTSEN, RUSSELL L. CECIL, R. H. FREYBERG, and W. H. KAMMERER, New York.

Information About Arthritis and Rheumatism.

RUSSELL L. CECIL and R. W. LAMONT-HAVERS, Arthritis and Rheumatism Foundation, New York.

Rheumatoid Arthritis: Diagnosis and Treatment.

DWIGHT C. ENSIGN and JOHN W. SIGLER, Henry Ford Hospital, Detroit, DONALD F. HILL and W. PAUL HOLBROOK, Tucson, Ariz.

Rheumatoid Spondylitis.

THEODORE A. POTTER and THEODORE B. BAYLES, Robert Breck Brigham Hospital, Boston.

Osteoarthritis.

BERNARD M. NORCROSS and SALVATORE R. LATONA, University of Buffalo and Buffalo General Hospital, Buffalo.

Self-Help Devices for the Arthritic.

EDWARD W. LOWMAN, Institute of Physical Medicine and Rehabilitation, New York.

Rheumatoid Arthritis: A Systemic Inflammatory Disease of the Connective (Collagen) Tissue.

ELAM TOONE, GORDON HENNIGAR, and JOHN VAUGHAN, Medical College of Virginia, Richmond, Va.

SECTION EXHIBITS

Each of the 21 sections of the Scientific Assembly has arranged a group of exhibits dealing with the various branches of medicine.

Section on Anesthesiology

The representative to the Scientific Exhibit from the Section on Anesthesiology is SCOTT M. SMITH, Salt Lake City.

Function of the Committee on Placement of the American Society of Anesthesiologists.

IRVING M. PALLIN, Brooklyn, N. Y.

Postgraduate Education in Anesthesia.

ORAL B. CRAWFORD, Springfield, Mo., and J. JAY JACOBY, Columbus, Ohio.

Viadril: A Steroid Anesthetic Agent: Results in 1,000 Cases.

F. PAUL ANSBRO, ALBERT E. BLUNDELL, and J. C. SWEENEY JR., Brooklyn, N. Y., and JOHN PILLION, Lawrence, Mass.

Antisecretory Drugs.

JOHN ADRIANI and WILLIAM TROTTI, Charity Hospital, New Orleans.

Narcotic Antagonists.

FRANCIS F. FOLDES, L. RENDELL-BAKER, D. BACKNER, L. R. KOUKAL, and A. A. CONTE, Mercy Hospital, Pittsburgh.

The Use of a Steroid for Narcosis.

WILLIAM S. HOWLAND and J. WELDON BELLVILLE, New York.

Epidural Anesthesia in General Surgery.

P. C. LUND and JOHN C. CWIK, Conemaugh Valley Memorial Hospital, Johnstown, Pa.

Pulmonary Edema: Antifoam Agents.

REUBEN C. BALAGOT, ROSAURO MA. REYES, GARETH B. GISH, and MAX S. SADOVE, University of Illinois College of Medicine, Chicago.

Physiological Treatment of Asphyxia Neonatorum.

WILLIAM K. BANNISTER and DAVID M. LITTLE, Hartford Hospital, Hartford, Conn.

Dyclonine: A Topical Anesthetic with Antimicrobial Properties.

P. A. BOYER JR., B. E. ABREU, and H. J. FLORESTANO, Indianapolis.

The Evolution of Laryngoscopes for the Anesthesiologist.

BARNETT A. GREENE and BERNARD S. GOFFEN, Brooklyn, N. Y.

Methitural: An Induction Anesthetic: Electrocardiogram Studies.

I. M. RIFFIN, St. Vincent's Hospital, Upper Montclair, N. J., and MAX BLOCK, Mountainside Hospital, Montclair, N. J.

Di-Ethyl Ether Analgesia.

JOSEPH F. ARTUSIO JR., New York.

Section on Dermatology

The representative to the Scientific Exhibit from the Section on Dermatology is SAMUEL M. BLUEFARB, Chicago.

Tuberculosis of the Skin.

ROBERT F. TILLEY, JOHN ADAMS JR., CHESTER N. FRAZIER, and ROBERT GRIESEMER, Massachusetts General Hospital and Harvard Medical School, Boston, and GEORGE ODLAND, Seattle.

Dermatological Preparations.

Louis C. Zopf and Seymour Blaug, the United States Pharmacopeia, New York.

Developments in Rotary Abrasive Techniques for the Removal of Acne Scars and Other Cosmetic Defects.

Joseph J. Eller and William D. Eller, New York.

Photosensitivity: Screening with Antimalarials.

Theodore Cornbleet, University of Illinois College of Medicine, Chicago.

Topical Steroid Therapy.

Harry M. Robinson Jr., Raymond C. V. Robinson, Morris M. Cohen, and John F. Strahan, University of Maryland School of Medicine, Baltimore.

In Vitro Blister Formation.

Richard B. Stoughton, University of Chicago, the School of Medicine, Chicago.

Dermatological Lesions Seen in General Practice.

Richard J. Rowe and Harland C. Dangle, Marshfield Clinic, Marshfield, Wis.

The Human Ear Canal.

Eldon T. Perry and Walter B. Shelley, Duhring Laboratories, Hospital of University of Pennsylvania, Philadelphia.

Cytodiagnosis of Cutaneous Malignancy.

Frederick Urbach, Eugene M. Burke, and Herbert Traenkle, Roswell Park Memorial Institute, Buffalo.

Cutaneous Tumors.

Julius E. Ginsberg, Chicago, and Malcolm C. Spencer, Danville, Ill.

The Phylogeny of Hair.

Hans Elias, Jack Shapiro, and Seymour Bortner, Chicago Medical School, Chicago.

Ringworm Contracted from Animals: A Public Health Problem.

William Kaplan, Communicable Disease Center, U. S. Public Health Service, Chamblee, Ga.

Section on Diseases of the Chest

The representative to the Scientific Exhibit from the Section on Diseases of the Chest is Edwin R. Levine, Chicago. The Section is also sponsoring the *Special Exhibit on Pulmonary Function Testing.*

Special Exhibit on Pulmonary Function Testing

The Special Exhibit on Pulmonary Function Testing is presented by the Section on Diseases of the Chest. The exhibit emphasizes practical problems in the establishment of a "lung station" suitable for a hospital or clinic, i. e., a laboratory designed to aid in diagnosis, prognosis, therapy, and the evaluation of disability in pulmonary disease in much the same manner that a "heart station" serves the needs of clinicians concerned with heart disease. A large group of demonstrators will assist with the exhibit.

Antimicrobial Therapy in Tuberculosis.

Francis J. Murray, Tuberculosis Program, U. S. Public Health Service, Washington, D. C.

Activation of Tuberculosis by Corticosteroid Therapy.

George S. Berg, William Lester, E. A. Piszczek, and Eli Shulruff, Suburban Cook County Tuberculosis Sanitarium, Hinsdale, Ill.

Tuberculosis Today.

Albert R. Allen and James K. Yu, Central Washington Tuberculosis Hospital, Selah, Wash.

Missed Diagnoses.

Julius L. Wilson, National Tuberculosis Association, New York.

Further Studies on the Use of the Corppin as a Skin Testing Medium.

Harry Shubin, Philadelphia, and Harry Corper, Derby, Colo.

Patterns of Cardiovascular Pressure Pulses Obtained by Catheterization.

Aldo A. Luisada and C. K. Liu, Chicago Medical School, Chicago.

Bronchial Adenoma.

Coleman B. Rabin, O. H. Friedman, and S. Gurman, New York.

The Use of Mechanical Respirators by the Anesthetist, Surgeon, and Internist.

E. Trier Morch, Edward E. Avery, Geraldine Light, and John Cunningham, Chicago.

Mitral Insufficiency: Correction by Polar Cross Plication of the Annulus Fibrosis.

Henry T. Nichols, Clarence Denton, and Joseph F. Uricchio, Hahnemann Medical College, Philadelphia.

Oxygen Tent Therapy.

Albert H. Andrews Jr., Respiration Laboratory, St. Luke's Hospital, Chicago.

Surgical Correction of Mitral Insufficiency.

Victor P. Satinsky, E. W. Hayes Jr., Robert Kuhn, Lauro deVera, and E. V. Kompaniez, Temple Hospital, Los Angeles.

Surgery of Mitral Insufficiency.

Robert P. Glover, Julio C. Davila, Robert G. Trout, and O. Henry Janton, Philadelphia.

Bronchography Using Sulfanilamide-Lipiodol Suspension.

John E. Rayl and Warren C. Evans, Veterans Administration, Oteen, N. C.

After Myocardial Infarction: The Functional Circulatory Consequences.

George R. Meneely, Con O. T. Ball, and F. T. Billings Jr., Vanderbilt University School of Medicine, and George B. Brothers, R. S. Anderson and J. Thomas, Meharry Medical College, Nashville, Tenn.

Experimental Methods for Producing a Collateral Circulation to the Heart Directly from the Left Ventricle.

Alfred Goldman, Martin Channin, Eugene Roberts, En Shu Chang, L. M. Ramirez, Kiyoshi Kuramoto, Sherman H. Strauss, and Myron Prinzmetal, City of Hope Medical Center, Duarte, Calif.

Physiological and Hormonal (Prednisone) Therapy in Bronchial Asthma and Pulmonary Emphysema.

Gustav J. Beck, Hylan A. Bickerman, Mato Marinovich, and Alvan L. Barach, New York.

Eight Years' Experience with Pulmonary Biopsy.

Neil C. Andrews and Karl P. Klassen, Ohio State Medical Center, Columbus, Ohio.

Section on Experimental Medicine and Therapeutics

The representative to the Scientific Exhibit from the Section on Experimental Medicine and Therapeutics is Joseph F. Ross, Los Angeles.

Malignant Carcinoid, a New Metabolic Disorder.

Albert Sjoerdsma, Luther L. Terry, and Sidney Udenfriend, National Heart Institute, Bethesda, Md.

Genesis of the Rat Skeleton.

DONALD G. WALKER, University of Oregon Medical School, and Z. T. WIRTSCHAFTER, Veterans Administration Hospital, Portland, Ore.

Fibrinogenopenic States.

MARIO STEFANINI and SERGIO I. MAGALINI, St. Elizabeth Hospital and Tufts University Medical School, Boston.

The Factors Influencing the Coronary Circulation.

ELIOT CORDAY, HERBERT GOLD, and LAURO B. DEVERA, Institute for Medical Research, Cedars of Lebanon Hospital, and University of California at Los Angeles School of Medicine, Los Angeles.

Chlorpheniremine Maleate in the Prophylaxis of Nonhemolytic Transfusion Reactions.

FREDERICK M. OFFENKRANTZ and GEORGE BABCOCK JR., Rahway General Hospital, Rahway, N. J.

Effects of Massive Prednisolone Therapy in Leukemia.

JOSEPH M. HILL, G. J. MARSHALL, and D. J. FALCO, Dallas.

A New Oral Diuretic with Minimal Side-Effects.

C. G. VAN ARMAN, H. R. DETTELBACH, and J. P. HOGAN, G. D. Searle & Co., Chicago.

Use of Rabbit Aortic Strip in Diagnosis of Pheochromocytoma.

OSCAR M. HELMER and B. L. MARTZ, Lilly Laboratory for Clinical Research, General Hospital, Indianapolis.

A New Organic Fibro-Cellulose Powder for Exudative Diseases of the Skin: Results in 523 Cases.

CLEVELAND J. WHITE, Stritch School of Medicine of Loyola University, and Mercy, West Suburban, and Norwegian-American hospitals, Chicago.

The Evaluation of Bronchodilator Drugs in the Treatment of Asthma.

G. L. SNIDER, D. B. RADNER, and M. M. MOSKO, Michael Reese Hospital, Chicago.

Phenoxymethyl Penicillin: Pharmacological and Therapeutic Studies: Massive Doses and Treatment of Serious Infections.

EDWARD L. QUINN, FRANK COX JR., JAMES M. COLVILLE, and JOSEPH TRUANT, Henry Ford Hospital, Detroit.

Echographic Cancer Detection and Diagnosis.

J. J. WILD and JOHN M. REID, St. Barnabas Hospital, Minneapolis.

Nasal Carrier Rates of Pathogenic Bacteria in Physicians: Epidemiology and Transmission.

ROSS S. BENHAM and ISABELLE HAVENS, University of Chicago, the School of Medicine, Chicago, and J. J. LANDY, University of Oklahoma School of Medicine, Oklahoma City.

Sulfamethoxypyridazine: A New Antibacterial Sulfonamide.

S. M. HARDY, B. W. CAREY, J. F. MONROE, and C. H. DEMOS, Lederle Laboratories, Pearl River, N. Y.

Hypertension: Pharmacodynamics of Therapy.

JOHN H. MOYER, RALPH V. FORD, EDWARD W. DENNIS, ROBERT MCCONN, and COLEMAN CAPLOVITZ, Baylor University College of Medicine, Houston, Texas.

Prednisone and Prednisolone in Experimental Bacterial Infections and Toxemia.

H. SENECA, O. KUPYN, and A. KOZAR, College of Physicians and Surgeons, Columbia University, and Presbyterian Hospital, New York.

Blood Dialyzers, Blood Oxygenators, and Blood Pumps.

ARTHUR E. MACNEILL and JOHN E. DOYLE, Buffalo.

Novobiocin: A New Antibiotic.

AUGUSTUS GIBSON, CHARLES E. LYGHT, ELMER ALPERT, and ROBERT F. STERNER, Merck & Co., Inc., Rahway, N. J.

Lysine Needs in Nutritional Stress of the Aged.

ANTHONY A. ALBANESE, REGINALD A. HIGGONS, and LOUISE A. ORTO, St. Luke's Convalescent Hospital, Greenwich, Conn.

The Action of Mercurial Diuretics and the Fractionation of Excretory Products.

CARROLL A. HANDLEY, JOHN H. MOYER, and R. A. SEIBERT, Baylor University College of Medicine, Houston, Texas.

Headache.

BERNARD JUDOVICH, GOLDA R. NOBEL, PEDRO POLAKOFF, and WILLIAM SAGEN, Philadelphia.

The Relationship of Exophthalmos to Disorders of the Thyroid.

WILLARD BARTLETT, St. Louis University School of Medicine, St. Louis.

Section on Gastroenterology and Proctology

The representatives to the Scientific Exhibit from the Section on Gastroenterology and Proctology are WILLIAM H. DEARING, Rochester, Minn., and WILLARD H. BERNHOFT, Buffalo.

The Use of Reserpine in Gastroenterology: Its Effect upon Gastric Secretion.

J. ALFRED RIDER, JOHN O. GIBBS, JOYCE SWADER, LOURDES F. AGCAOILI, MAUREEN MEIKLE, DEAN W. FRAZIER, EDWARD H. ADRAMS, and JERE DEROIN, University of California Medical Center, San Francisco.

Polyps of the Large Intestine: Pathology and Histogenesis.

ANTONIO VALDES-DAPENA and WILLIAM J. BECKFIELD, Graduate Hospital, University of Pennsylvania School of Medicine, and MARIE A. VALDES-DAPENA, Woman's Medical College, Philadelphia.

Value of Proper Dosage of Anticholinergic Drugs in Treatment of Peptic Ulcer: Optimal Effective Dose.

DAVID C. H. SUN and HARRY SHAY, Temple University School of Medicine, Philadelphia.

Chronic Ulcerative Colitis: Diagnostic and Therapeutic Considerations.

N. C. HIGHTOWER, A. C. BRODERS JR., R. D. HAINES, A. W. SOMMER, and J. F. MCKENNEY, Scott and White Clinic, Temple, Texas.

Erosive Esophagitis.

GORDON MCHARDY, ROBERT MCHARDY, CLAUDE CRAIGHEAD, and IRBY J. HURST, Brown-McHardy Clinic, Louisiana State University School of Medicine, New Orleans.

Intralumen Pressures from Upper Gastrointestinal Tract: Measurement and Significance.

E. C. TEXTER JR., H. C. MOELLER, H. W. SMITH, J. H. STICKLEY, and C. J. BARBORKA, Northwestern University Medical School, Chicago.

Esophageal Motility: Dynamics of Deglutition in Health and Disease.

C. F. CODE, A. M. OLSEN, F. E. DONOGHUE, H. A. ANDERSEN, B. CREAMER, F. E. FYKE JR., and A. H. BULBULIAN, Mayo Clinic and Mayo Foundation, Rochester, Minn.

Recent Experimental and Clinical Experiences with Antacid Therapy in Peptic Ulcer.

LEONIDAS H. BERRY, JONAS ADOMAVICIUS, ROBERT SCHOOP, and JUANITA PURNELL, Chicago.

Section on General Practice

The representative to the Scientific Exhibit from the Section on General Practice is CHARLES E. MCARTHUR, Olympia, Wash. The section is conducting physical examinations for physicians.

Laboratory Techniques in the Diagnosis of Communicable Diseases.

R. B. HOGAN, M. M. BROOKE, G. R. COOPER, D. S. MARTIN, and M. SCHAEFFER, Communicable Disease Center, Public Health Service, U. S. Department of Health, Education, and Welfare, Atlanta, Ga.

Early Detection of Glaucoma.

FRANKLIN M. FOOTE, WILLIS S. KNIGHTON, and VIRGINIA SMITH BOYCE, National Society for the Prevention of Blindness, New York.

A New Approach to Improving Abnormal Behavior in Geriatrics.

JOHN T. FERGUSON and WILLIAM H. FUNDERBURK, Traverse City State Hospital, Traverse City, Mich.

Balanced Mechanisms in Hypertension.

JESSE L. SERBY, Syracuse, N. Y.

Significance and Control of Bronchopulmonary Disease: A Ten-Year Study.

WALTER FINKE, Rochester, N. Y.

The Body Fluids: Foundation Facts, Clinical Diagnosis, Therapy.

W. D. SNIVELY JR., M. J. SWEENEY, and MARTHA WESSNER, St. Marys Hospital, Evansville, Ind.

Control of Cervical Carcinoma by General Population Screening: The Floyd County Project.

H. E. NIEBURGS, Beth El Hospital, New York.

The Use of Chlorpromazine in General Medical Practice.

FRANK J. BONELLO, St. Paul.

Fluid and Electrolyte Balance.

JAMES GRAHAM, Springfield, Ill.

Carcinoma of the Stomach, Early Diagnosis.

HU C. MYERS, Philippi, W. Va.

Premenstrual Tension Syndrome.

EDUARD EICHNER and HELEN EICHNER, Mount Sinai Hospital, Cleveland.

Hemorrhage and Hypofibrinogenemia: Clinical and Experimental Studies.

C. PAUL HODGKINSON, PAUL W. PIPER, MELVIN A. BLOCK, and DONALD G. REMP, Henry Ford Hospital, Detroit.

Pruritus Ani: Present-Day Treatment.

ROBERT TURELL, New York.

Parkinson's Disease: Importance of Therapeutic Exercises in Its Management.

E. C. CLARK, D. W. MULDER, D. J. ERICKSON, B. G. CLEMENTS, and C. S. MACCARTY, Mayo Clinic and Mayo Foundation, Rochester, Minn.

Cardiac Glycosides: Recent Advances and Their Application in Therapeutics.

ARTHUR C. DEGRAFF, LEONARD B. GUTNER, and LAWRENCE KRYLE, New York University and Bellevue Medical Center, New York, and ARTHUR BERNSTEIN, Newark, N. J.

The Rationale of Trypsin Therapy in Acute Inflammatory Disorders.

IRVING INNERFIELD, A. ALLEN GOLDBLOOM, IRVING S. SHINER, and MARCUS FEINSTEIN, New York Medical College, New York.

Evaluation of Xanthine Drugs in Chronic Pulmonary Diseases: Use of a New Respiratory Index.

S. WILLIAM SIMON, Brown General Hospital, Veterans Administration Center, Dayton, Ohio.

The Collagen Diseases.

GEORGE COOPER JR., W. H. MELTON, and EDWARD P. CAWLEY, University of Virginia Hospital, Charlottesville, Va.

Birth Lesions in Newborn Infants.

PH. SCHWARTZ, Warren State Hospital, Warren, Pa.

A Yearly Physical Examination for Every M.D.

This exhibit on physical examinations is presented by the Section on General Practice with the cooperation of the American Academy of General Practice and the National Tuberculosis Association. The exhibit offers electrocardiographic examination and chest x-rays to visiting physicians.

Section on Internal Medicine

The representative to the Scientific Exhibit from the Section on Internal Medicine is HENRY T. RICKETTS, Chicago.

Management of Anticoagulant Therapy by a Simple Blood Prothrombin Test.

BENJAMIN MANCHESTER, George Washington University School of Medicine, Washington, D. C.

3D Models of Heart Sounds and Murmurs.

GEORGE D. GECKELER, WILLIAM LIKOFF, DANIEL MASON, and NORMAN B. BURKE, the Institute for Cardiovascular Research of the Hahnemann Medical College and Hospital, Philadelphia, and ROBERT R. RIESZ, Bell Telephone Laboratories, Murray Hill, N. J.

A Clinical Laboratory Investigation of Coagulation Disorders.

J. K. LEWIS, University of Pittsburgh School of Medicine, Pittsburgh, and HERON O. SINGHER and M. J. POHALA, Ortho Research Foundation, Raritan, N. J.

The C-Reactive Protein Determination in Heart Disease.

IRVING G. KROOP and NATHAN H. SHACKMAN, Jewish Chronic Disease Hospital and Jewish Hospital of Brooklyn, Brooklyn.

The Octogenarian Electrocardiogram.

MAXWELL L. GELFAND, New York University Postgraduate Medical School, New York.

The American Heart Association Serves the Physician.

CHARLES D. MARPLE, ROBERT S. WARNER, LEONARD H. SCHUYLER, and ARTHUR S. CAIN, American Heart Association, New York.

Transthoracic Left Heart Catheterization in Valve Disease.

DON L. FISHER, EDWARD M. KENT, MAURICE H. MCCAFFREY, WILLIAM B. FORD, and JOHN F. NEVILLE, Allegheny General Hospital, Pittsburgh.

Serum Glutamic Oxaloacetic Transaminase (G. O. T.) in Myocardial Infarction.

BERNARD H. OSTROW, DANIEL STEINBERG, JOHN M. EVANS, and HOWARD E. TICKTIN, George Washington University School of Medicine, Washington, D. C., and National Heart Institute, National Institutes of Health, Bethesda, Md.

Rheumatoid Arthritis.

EUGENE F. TRAUT, CHESTER B. THRIFT, JOSEPH E. ALLEGRETTI, H. PAUL CARSTENS, HARRIET M. CLARK, and GEORGE J. GUMERMAN, Cook County Hospital, Hektoen Institute for Medical Research and University of Illinois College of Medicine, Chicago.

Corticotropin Zinc Hydroxide in the Collagen Diseases.
HARRY E. BANGHART and RICHARD K. D. WATANABE, Philadelphia.

Complications Associated with Diabetes Mellitus.
WILLIAM R. KIRTLEY, Indianapolis, and HENRY T. RICKETTS, Chicago, American Diabetes Association.

Management of the Hypertensive Patient.
JOSEPH C. EDWARDS, Washington University School of Medicine, Barnes and St. Luke's Hospitals, St. Louis.

Adrenal Steroid Therapy in Allergic Disease.
EMANUEL SCHWARTZ, State University of New York, College of Medicine at New York City, and the Long Island College Hospital, Brooklyn, N. Y.

Studies in Headache.
ADRIAN M. OSTFELD, HELEN GOODELL, and HAROLD G. WOLFF, The New York Hospital, New York.

Struma Lymphomatosa: Primary Thyroid Failure with Compensatory Thyroid Enlargement.
PENN G. SKILLERN, GEORGE CRILE JR., E. PERRY MCCULLAGH, JOHN B. HAZARD, HELEN BROWN, and LENA A. LEWIS, the Cleveland Clinic Foundation, Cleveland.

Course of Sarcoidosis.
MAURICE SONES and HAROLD L. ISRAEL, Henry Phipps Institute, Graduate School, University of Pennsylvania School of Medicine, and Woman's Medical College of Pennsylvania, Philadelphia.

Peripheral Arterial Insufficiency: An Evaluation of Vasodilating Measures.
IRWIN D. STEIN, Mount Vernon, N. Y.

Epidemiology of Influenza as Demonstrated by a Study of Serum Pools.
GORONWY O. BROUN and ROSE RITA SCHMIDT, St. Louis University School of Medicine, St. Louis.

Auscultatory Variations in Congenital Heart Disease.
EDMUND H. REPPERT, JOHN J. THORPE, RICHARD HAMILTON, RICHARD HOVDA, C. A. POINDEXTER, and J. SCOTT BUTTERWORTH, New York University Postgraduate Medical School, New York, and THOMAS W. MATTINGLY, Walter Reed Army Hospital, Washington, D. C.

Section on Laryngology, Otology and Rhinology

The representative to the Scientific Exhibit from the Section on Laryngology, Otology and Rhinology is WALTER E. HECK, San Francisco.

Microscopically Benign but Clinically Malignant Lesions of the Head and Neck.
FREDERIC J. POLLOCK, University of Illinois, Illinois Eye and Ear Infirmary, and PAUL B. SZANTO, Cook County Hospital, Chicago.

Early Nasal Injuries: A Factor in Facial and Dental Deformity.
MAURICE H. COTTLE, GEORGE G. FISCHER, and ROLAND M. LORING, Chicago, RALPH H. RIGGS, Shreveport, La., and IVAN W. PHILPOTT, Denver.

Mobilization of Stapes for Otosclerotic Deafness.
SAMUEL ROSEN, New York.

Branchial Anomalies.
G. DONALD ALBERS, Grand Rapids, Mich.

Headache: Diagnosis and Treatment.
RAYMOND L. HILSINGER, Cincinnati.

The Significance of a Lump in the Neck.
EDWARD C. BRANDOW JR., BENJAMIN M. VOLK, and KENNETH B. OLSON, Albany Medical College, Albany, N. Y.

Secretory Sialography in Health and Disease.
IRVING M. BLATT, PHILIP RUBIN, JAMES H. MAXWELL, JOHN F. HOLT, and JOHN E. MAGIELSKI, University of Michigan Medical School, Ann Arbor.

Surgical Anatomy of the Head and Neck.
JOHN M. LORÉ JR., St. Clare's Hospital, New York.

Section on Military Medicine

The representative to the Scientific Exhibit from the Section on Military Medicine is ROBERT V. SCHULTZ, Washington, D. C.

Experimental Hepatic Surgery Employing Differential Hypothermia.
CHARLES HUGGINS and EDWIN L. CARTER, Naval Medical Research Institute, National Naval Medical Center, Bethesda, Md.

The Practice of Medicine in the Armed Forces.
S. O. WAIFE, Armed Forces Medical Publication Agency, Washington, D. C.

Clinical Diagnostic Studies Utilizing Radioactive Isotopes.
SYLVESTER F. WILLIAMS, ELMER R. KING, and FRANCIS W. CHAMBERS, U. S. Naval Hospital, Bethesda, Md.

The Procurement, Storage, and Clinical Use of Tissue Homografts.
GEORGE W. HYATT, JOHN W. SAVILLE, and JERRY W. DRAHEIM, U. S. Naval Medical School, Bethesda, Md.

Determination of Protein-Bound Iodine, Leffler Method.
FRANK M. TOWNSEND, WILLIAM J. REALS, and RICHARD E. DANIELSON, St. Joseph Hospital, Wichita, Kan.

The United States Air Force Medical Education Program.
PATRICK H. HOEY, R. HOWARD LACKAY, and JAMES T. HADEN, Office of the Surgeon General, Department of the Air Force, Washington, D. C.

Retinal Changes Produced by High-Intensity Ionizing Radiation.
DAVID V. I. BROWN and PAUL A. CIBIS, United States Air Force School of Aviation Medicine, Randolph Air Force Base, Texas.

Laminography in Neuroradiology.
ROLAND A. MANFREDI and FRANCIS KRUSE JR., Parks Air Force Base, Calif.

Superior Vena Cava Syndrome.
M. MURRAY SCHECHTER, Griffiss Air Force Base, N. Y.

Specialty Treatment Centers in Medical Support of Combat Operations.
PAUL E. TESCHAN and ARTHUR D. MASON JR., Surgical Research Unit, Brooke Army Medical Center, Fort Sam Houston, Texas.

Studies of Clinical and Experimental Frostbite.
JOSEPH R. BLAIR, Wellesley, Mass., and J. PETER KULKA and RICHARD SCHATZKI, Harvard Medical School, Boston.

The Pulmonary Coin Lesion: A Harmless Looking Killer.
S. W. FRENCH III, HERBERT T. BERWALD, and JOSEPH L. HANNON, Letterman Army Hospital, San Francisco.

Activities of the U. S. Army Medical Reserve.
JAMES H. KIDDER, Office of the Surgeon General, Department of the Army, Washington, D. C.

The Prophylactic Value of Antibiotics in Traumatic Wounds.

JAY P. SANFORD and CARL W. HUGHES, Walter Reed Army Medical Center, Washington, D. C.

Medical Aspects of Sport Diving.

EDWARD H. LANPHIER, Experimental Diving Unit, Naval Gun Factory, Washington, D. C.

Section on Nervous and Mental Diseases

The representative to the Scientific Exhibit from the Section on Nervous and Mental Diseases is G. WILSE ROBINSON JR., Kansas City, Mo.

Strokes: A Short Course in Diagnosis and Treatment.

KEITH W. SHELDON, Cleveland.

Automatically Controlled Stereo-Serio-Cerebral Angiography.

J. M. SANCHEZ-PEREZ, Mexico City, Mexico.

Ocular Aspects of Intracranial Arterial Aneurysms.

JOSEPH E. ALFANO, Northwestern University Medical School, Chicago.

Age Changes in the Human Nervous System.

WARREN ANDREW, Bowman Gray School of Medicine, Winston-Salem, N. C.

Alterations in the Central Nervous System Associated with Various Fungus Infections.

LOUIS D. BOSHES, IRVING C. SHERMAN, CHARLES J. HESSER, ALBERT MILZER, and HELEN MACLEAN, Michael Reese Hospital and Northwestern University Medical School, Chicago.

Laryngospasm in Electroshock.

E. J. FOGEL, J. T. MCCLOWRY, and KENNETH HINDERER, Veterans Administration Hospital, and University of Pittsburgh School of Medicine, Pittsburgh.

Alcoholic Brain Disease.

A. E. BENNETT, L. T. DOI, and G. L. MOWERY, Berkeley, Calif.

Treatment of Headache: Pharmacology.

ARNOLD P. FRIEDMAN and SAMUEL PILCHMAN, Montefiore Hospital, New York.

Referral to a Psychiatrist.

RAYMOND E. REINERT, Veterans Administration Hospital, Topeka, Kan.

The Effect of Chlorpromazine on the Institutional Care of Retarded Children.

JUDITH H. RETTIG and CARL M. ROSENBERG, Columbus State School, Columbus, Ohio.

Simplified Method of Cerebral Angiography.

MAURICE L. SILVER, Providence, R. I.

Progress Radiographs in Cranial Trauma.

HARRY W. SLADE and SIMON SPENDIARIAN, Western Reserve University School of Medicine and City Hospital, Cleveland.

Scalenus Anticus Syndrome.

AVERILL STOWELL, Tulsa, Okla.

Thymectomy in Myasthenia Gravis.

ROBERT S. SCHWAB, BENJAMIN CASTLEMAN, OLIVER COPE, RICHARD SWEET, JAMES VANDERVEEN, and HENRY R. VIETS, Massachusetts General Hospital, Boston.

Use of Promazine in the Management of Acutely Disturbed Patients.

JOHN D. SCHULTZ, JOSEPH F. FAZEKAS, PAUL D. SULLIVAN, and JAMES G. SHEA, District of Columbia General Hospital, Washington, D. C.

Section on Obstetrics and Gynecology

The representative to the Scientific Exhibit from the Section on Obstetrics and Gynecology is FREDERICK H. FALLS, River Forest, Ill.

Version and Extraction.

FREDERICK H. FALLS and CHARLOTTE S. HOLT, University of Illinois College of Medicine and Illinois State Department of Public Health, Chicago.

Transvaginal Pudendal Nerve Block.

PRESTON LEA WILDS and MILTON L. MCCALL, Louisiana State University School of Medicine, New Orleans.

Use of Chlorpromazine in Gynecological Surgery.

WILLIAM D. CHAMBLIN and JOHN CORBIT JR., Philadelphia.

Local Infiltration Versus Pudendal Block Anesthesia in Obstetrics and Gynecology.

EDWARD W. KLINK and GORDON T. BURNS, Rockford Memorial Hospital, Medical Clinic of Rockford, Rockford, Ill.

Transcervical Resection in the Uterine Canal.

W. B. NORMENT and C. HENRY SIKES, Greensboro, N. C.

Phasemicroscopy in Office Cancer Screening.

M. EDWARD DAVIS and GEORGE L. WIED, University of Chicago, the School of Medicine, Chicago.

Biodynamic Study of Uterotubal Insufflation: Differentiation Between Tubal and Uterine Oscillation.

JOHN STAVORSKI, CARL G. HARTMAN, I. C. RUBIN, and GEORGE D. RICHARDSON, Ortho Research Foundation, Raritan, N. J.

Trichomonads and Trichomoniasis.

R. V. CHAPPLE and ALFRED B. KUPFERBERG, Ortho Research Foundation, Raritan, N. J.

Hiatal Hernia in Pregnancy.

WILLIS E. BROWN and JAMES C. ATKINSON, University of Arkansas School of Medicine, Little Rock, Ark.

The Clinical Value of Frog and Toad Pregnancy Tests.

EDWARD H. HON and J. MCL. MORRIS, Yale University School of Medicine, New Haven.

Therapeutic and Diagnostic Uses of Adrenal Corticoids in Gynecology.

HERBERT SPENCER KUPPERMAN, JEANNE A. EPSTEIN, MEYER E. BLATT, and LEE VOSBURGH, New York University College of Medicine, New York.

Section on Ophthalmology

The representative to the Scientific Exhibit from the Section on Ophthalmology is FRANK W. NEWELL, Chicago.

Retinopathy in Diabetes: A Thirty-Year Clinical Survey.

ROBERT C. HARDIN, T. L. JOHNSTON, HELEN G. KELLEY, and H. B. OSTLER, University Hospitals, Iowa City, Iowa.

The Newer Corticosteroids in Ophthalmology.

JOHN HARRY KING JR., Washington Clinic, and JACK W. PASSMORE, Ocular Research Unit, Walter Reed Army Medical Center, Washington, D. C.

Aids to Subnormal Vision.

DAVID VOLK, Western Reserve University School of Medicine, Cleveland.

Gonioscopy.

HAROLD G. SCHEIE, WILLIAM C. FRAYER, JULIA LLOYD, MARIE WILSON, and MARIE KERN, Hospital of the University of Pennsylvania, Philadelphia.

Cataracts in Vitamin-E-Deficient Turkey Embryos.

R. H. RIGDON, University of Texas Medical Branch, Galveston, J. R. COUCH and T. M. FERGUSON, A&M College, College Station, Texas.

Survey of Pathogenesis and Treatment of Retinal Venous Occlusions.

BERTHA A. KLIEN, University of Chicago, the School of Medicine, Chicago.

Amblyopia.

MARIE WILLIAMS, American Association of Orthoptic Technicians, Denver.

Modern Therapy of Uveitis.

DAN M. GORDON, New York Hospital-Cornell Medical Center, New York.

Herpetic Keratitis.

SAMUEL J. KIMURA and PHILLIPS THYGESON, University of California School of Medicine, San Francisco.

Section on Orthopedic Surgery

The representative to the Scientific Exhibit from the Section on Orthopedic Surgery is J. VERNON LUCK, Los Angeles.

Oblique Rotational Osteotomy.

T. GORDON REYNOLDS and W. A. SCHARFFENBERG JR., College of Medical Evangelists, Los Angeles.

Compression Neuropathy of the Median Nerve in the Carpal Tunnel.

GEORGE S. PHALEN and JAMES I. KENDRICK, Cleveland Clinic, Cleveland.

Arthrography of the Shoulder.

WILLIAM R. SNEED JR., GRAHAM A. KERNWEIN, and BERTIL ROSEBERG, Rockford Memorial Hospital, Rockford, Ill.

The Effect of Compression on the Growth of Epiphyseal Bone.

L. J. STROBINO, Utica, N. Y.; PAUL C. COLONNA and R. S. BRODEY, Philadelphia; and GEORGE O. FRENCH, San Luis Obispo, Calif.

Spondyloschisis and Spondylolisthesis in Children.

DAN R. BAKER, Guthrie Clinic, Sayre, Pa., and WILLIAM J. MCHOLICK, McBride Clinic, Oklahoma City.

Functional Fixation of Intracapsular Fractures of the Hip.

W. K. MASSIE, Lexington, Ky.

Bone Tumors: Analysis of 2,276 Primary Neoplasms of Bone Seen at the Mayo Clinic 1905-1955.

D. C. DAHLIN, R. K. GHORMLEY, E. D. HENDERSON, and M. B. COVENTRY, Mayo Clinic and Mayo Foundation, Rochester, Minn.

Treatment of Hip Dislocation Associated with Fracture of Head or Neck of the Femur.

GARRETT PIPKIN and DONALD K. PIPER, Kansas City, Mo.

Heredity of Short Thumbs.

ROBERT M. STECHER, Western Reserve University School of Medicine, Cleveland.

Section on Pathology and Physiology

The Section on Pathology and Physiology is cooperating in the *Special Exhibit on Fresh Tissue Pathology*. The representative to the Scientific Exhibit is FRANK B. QUEEN, Portland, Ore.

Special Exhibit on Fresh Tissue Pathology

The Special Exhibit on Fresh Tissue Pathology is presented by the Section on Pathology and Physiology with the cooperation of the Illinois Society of Pathologists and numerous individual pathologists.

Specimens of outstanding interest, as well as teaching value, have been gathered at St. Luke's Hospital, Chicago, and will be shown in freezer display cases. Numerous drawings, photographs and photomicrographs will help illustrate the specimens.

Demonstrations will be conducted continuously by a large corps of pathologists on duty at all times, including guest demonstrators.

The committee in charge consists of the following members:

JERRY J. KEARNS, Chicago, Chairman.
EDWIN F. HIRSCH, Chicago.
FREDERICK C. BAUER, Chicago, Co-chairman.

The Advisory Committee, consisting of officers of the Section on Pathology and Physiology, is as follows:

FRANK B. QUEEN, Portland, Ore., Chairman.
ROGER D. BAKER, Durham, N. C.
H. RUSSELL FISHER, Pasadena, Calif.
LALL G. MONTGOMERY, Muncie, Ind.
EDWIN F. HIRSCH, Chicago.

Guest demonstrators include nationally known pathologists from the various teaching institutions of the country who will serve on a definite schedule:

W. A. D. ANDERSON, Coral Gables, Fla.
JOHN J. ANDUJAR, Fort Worth, Texas.
OSBORNE A. BRINES, Detroit.
E. L. BURNS, Toledo, Ohio.
GEORGE H. FETTERMAN, Pittsburgh.
H. RUSSELL FISHER, Pasadena, Calif.
FRANK W. HARTMAN, Detroit.
CHARLES P. LARSON, Tacoma, Wash.
F. K. MOSTOFI, Washington, D. C.
ANDERSON NETTLESHIP, Little Rock, Ark.
ORLYN B. PRATT, Los Angeles.
ROBERT S. TOTTEN, Pittsburgh.
EMORY D. WARNER, Iowa City.

Other local pathologists who will assist with the demonstrations include the following:

GEORGE D. AMROMIN, Chicago.
MAX APPEL, Champaign, Ill.
RUTH B. BALKIN, Evanston, Ill.
EARL P. BENDITT, Chicago.
FRANK J. BICKNELL, Chicago.
ISRAEL DAVIDSOHN, Chicago.
GERALD S. DEAN, Highland Park, Ill.
DENNIS B. DORSEY, Danville, Ill.
WERNER F. EISENSTAEDT, Chicago.
HERBERT P. FRIEDMAN, Urbana, Ill.
HAROLD A. GRIMM, Chicago.
CORNELIUS S. HAGERTY, Chicago.
HENRY H. HALLEY, Alton, Ill.
JAMES B. HARTNEY, Chicago.
WELLAND A. HAUSE, Decatur, Ill.
JAMES W. HENRY, Evanston, Ill.
DAVID O. HOLMAN, Springfield, Ill.
GEOFFREY KENT, Chicago.
LESTER S. KING, Chicago.
AARON LEARNER, Chicago.
ELIZABETH A. MCGREW, Chicago.
JOHN E. MALONEY, Dixon, Ill.
LOWELL E. MARTIN, Moline, Ill.
COYE C. MASON, Chicago.
A. R. K. MATTHEWS, Rockford, Ill.
WILLIAM P. MAVRELIS, Chicago.

Franklin J. Moore, Chicago.
Hans Popper, Chicago.
Benjamin H. Spargo, Chicago.
Paul B. Szanto, Chicago.
Paul A. Van Pernis, Rockford, Ill.
Julius Weinberg, Chicago.
Mark C. Wheelock, Chicago.
Robert W. Wissler, Chicago.

Mucormycosis.

Roger D. Baker, Veterans Administration Hospital, and Duke University School of Medicine, Durham, N. C.

The Pathology of Virus Diseases in Newborn Infants.

Daniel Stowens, Armed Forces Institute of Pathology, Washington, D. C.

The Thyroid Gland in Pregnancy.

C. A. Hellwig, R. P. Stoffer, Irene A. Koeneke, and V. E. Chesky, Hertzler Clinic and Hertzler Research Foundation, Halstead, Kan.

Treponema Pallidum Complement Fixation Test.

Harold J. Magnuson and Joseph Portnoy, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C.

The Thoracic Duct in Malignant Disease.

Joseph M. Young, Veterans Administration Hospital, Memphis, Tenn.

A Better Understanding of Anion-Cation (Acid-Base) Balance.

Harry F. Weisberg, Mount Sinai Medical Research Foundation and Chicago Medical School, Chicago.

Certification of Medical Technologists.

Lall G. Montgomery and Ruth Drummond, Registry of Medical Technologists of the American Society of Clinical Pathologists, Muncie, Ind.

Physiological States in Sleep.

Chandler McC. Brooks, Brian F. Hoffman, and E. E. Suckling, State University of New York College of Medicine at New York City, Brooklyn, N. Y.

The History of Goiter in Spain and Among Jews.

Isidor Greenwald, New York University College of Medicine, New York.

Some Physiological Aspects of Aging.

N. W. Shock, National Heart Institute, Bethesda, Md., and Baltimore City Hospitals, Baltimore, Md.

Section on Pediatrics

The representative to the Scientific Exhibit from the Section on Pediatrics is F. Thomas Mitchell, Memphis, Tenn.

The Use of an Oral Electrolyte–Carbohydrate Mixture.

Carl A. Gagliardi and Marjorie R. Stewart-Gagliardi, the Lynn Clinic and Hospital, Detroit.

Pituitary-Adrenal Function in Diseases of Children.

Vincent C. Kelley, Robert S. Ely, and Alan K. Done, University of Utah School of Medicine, Salt Lake City.

Perinatal Mortality.

George M. Wheatley, W. P. Shepard, and John McIver, Metropolitan Life Insurance Co., New York.

Repair of Interatrial Septal Defects by the Closed Method (Atrio-Septo-Pexy).

Houck E. Bolton, Harry Goldberg, Daniel F. Downing, and Demetrious P. Lazarides, Bailey Thoracic Clinic, Philadelphia.

Diagnosis and Treatment of Cystic Fibrosis of the Pancreas, Lungs, etc.

Gordon E. Gibbs, University of Nebraska College of Medicine, Omaha.

Pathology Associated with Jaundice in Infancy.

Albert M. Hand, Institute of Pathology, Memphis, Tenn.

The Operation of the Breast Milk Bank.

E. Robbins Kimball, Robert McGuigan, Ivan Rosenstern, Herbert Philipsborn, John Reichert Jr., and Joseph Rappaport, Evanston, Ill.

Intestinal Obstruction in Newborn Infants.

Willis J. Potts, W. L. Riker, Arthur DeBoer, and Thomas G. Baffes, Children's Memorial Hospital, Chicago.

Effective Treatment of a Growth Failure Syndrome in Children.

Louis S. Goldstein, Professional Hospital, Yonkers, N. Y.

A Study of Blood Pressure in Children Four to Eighteen Years of Age.

A. W. Graham, Chisholm, Minn.

Problem and Management of Constipation in Children.

Harry R. Litchfield, Brooklyn, N. Y.

Cutaneous Tumors in Childhood.

Harold W. Dargeon and Charlotte Tan, Memorial Center for Cancer and Allied Diseases, New York.

Experiences with Lente Insulin in Children.

Robert Lussky, Alvah L. Newcomb, Matthew M. Steiner, and Howard S. Traisman, Chicago.

Meconium Ileus, A Medical and Surgical Challenge.

Harry C. Bishop, John W. Hope, and C. Everett Koop, University of Pennsylvania School of Medicine and the Children's Hospital of Philadelphia, Philadelphia.

Treatment for Convulsive Disorders.

Ruth W. Baldwin, Charles Van Buskirk, and Grange S. Coffin, University Hospital, Baltimore.

Diagnosis and Treatment of Moniliasis in Pediatrics.

Bohdan Dobias, New York, and Walter Mitchell Jr., Newark, N. J.

Section on Physical Medicine

The representative to the Scientific Exhibit from the Section on Physical Medicine is Donald A. Covalt, New York, N. Y.

Training Techniques for Upper Extremity Amputees.

Bun L. Boynton, Rehabilitation Institute of Chicago, and Clinton Compere, Chicago.

Rehabilitation Follow-Up: A Medical Responsibility in Treating the Whole Man.

A. B. C. Knudson, F. J. Balsam, and J. H. Van Schoick, Veterans Administration, Washington, D. C.

The Multiphasis Approach in Rehabilitation.

Sedgwick Mead, Vallejo, Calif., and O. L. Huddleston, Santa Monica, Calif.

Disturbances of Space Perception in Hemiplegics and Its Relation to Gait Training.

Mieczyslaw Peszczynski and Jan H. Bruell, Highland View Hospital and Western Reserve University School of Medicine, Cleveland.

What Price Ambulation? A Study of the Indications and Contraindications for Paraplegic Ambulation.

EDWARD E. GORDON, Michael Reese Hospital, Chicago.

Venous Circulation Studies of the Lower Extremity Using a Radioactive Tracer.

HARRY T. ZANKEL, REGINALD A. SHIPLEY, and RICHARD E. CLARK, Veterans Administration Hospital, Cleveland.

Crossroads: A Community Rehabilitation Center in Action.

DEAN W. ROBERTS and JAYNE SHOVER, National Society for Crippled Children and Adults, Chicago, and ROY PATTON and K. R. MANNING, Crossroads Rehabilitation Center, Marion County Society for Crippled Children and Adults, Indianapolis.

Muscular Dystrophy: Electrophoretic Patterns, Diagnostic Electromyography, Management.

M. K. NEWMAN and W. D. PAUL, Detroit.

Safety: A Factor in the Functional Training of the Disabled.

MORTON HOBERMAN, ERBERT F. CICENIA, and HYMAN L. DERVITZ, New York State Rehabilitation Hospital, New York.

Applications of Electromyography in Clinical Medicine.

A. A. RODRIQUEZ, Y. T. OESTER, and J. J. FUDEMA, Stritch School of Medicine of Loyola University, Chicago.

Preventive Measures in the Management of the Hemiplegic.

RAY PIASKOSKI, ROBERT W. BOYLE, EDWIN C. WELSH, PAUL A. DUDENHOEFER, ALBERT M. COHEN, and DELORE WILLIAMS, Marquette University School of Medicine, Milwaukee.

Section on Preventive and Industrial Medicine and Public Health

The representative to the Scientific Exhibit from the Section on Preventive and Industrial Medicine and Public Health is PAUL A. DAVIS, Akron, Ohio.

Foreign Service Provides a World-Wide Clinical Laboratory.

H. VAN ZILE HYDE, JOHN C. EASON JR., and JOHN J. HANLON, Public Health Service, U. S. Department of Health, Education, and Welfare, and International Cooperation Administration, Washington, D. C.

Leptospirosis in Man and Animals.

ASA WINTER, Arlington, Va.

Intestinal Round Worm Infections.

ERNEST CARROLL FAUST, Tulane University School of Medicine, New Orleans, and HUGH R. GILMORE JR. and S. W. KIME JR., Armed Forces Institute of Pathology, Washington, D. C.

Cancer Control Through Early Detection.

CAESAR PORTES, JULIUS WEINBERG, and JOHN R. WOLFF, Cancer Prevention Center of Chicago, Inc., Chicago.

Industrially Disabled Back.

EARL F. HOERNER and HENRY M. KESSLER, Kessler Institute for Rehabilitation, West Orange, N. J.

Health Consultation with Exhibits.

BRUNO GEBHARD, Cleveland Health Museum, Cleveland.

Epidemiology as a Tool in Cancer Control.

CHARLES S. CAMERON and BREWSTER S. MILLER, American Cancer Society, Inc., New York.

Acerola Juice: Richest Natural Source of Vitamin C: Clinical Study in Infants.

NORMAN W. CLEIN, University of Washington School of Medicine and the Children's Clinic, Seattle.

Penicillin Reactions, Less than One Per Cent in over 19,000 Patients.

C. A. SMITH and MAURICE KAMP, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C.

Phosphate Ester Insecticide Poisoning.

D. O. HAMBLIN, HAROLD H. GOLZ, and C. BOYD SHAFFER, New York.

Accident Syndrome: A Clinical Approach.

M. S. SCHULZINGER, Cincinnati.

Arteriosclerotic Hearts at Work.

HOWARD HANSEN, N. K. WEAVER, and J. T. PERRET, Esso Standard Oil Co., Baton Rouge, La.

Effect of Prophylaxis on Rheumatic Heart Disease.

JOHN M. BRYAN and WILLIAM H. STEWART, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C.

The Eradication of Communicable Disease: A New Approach in International Public Health.

HAROLD BALLOU, World Health Organization, Washington, D. C.

Alcoholism Is a Disease.

MILDRED C. J. PFEIFFER, BERWYN F. MATTISON, J. THOMAS MILLINGTON, WILLIAM L. KEATON, and LAURA K. PASSMORE, Pennsylvania Department of Health, Harrisburg, Pa.

Fifty Years of Food and Drug Administration: Health Protection for You and Your Patient.

IRVIN KERLAN, Food and Drug Administration, U. S. Department of Health, Education, and Welfare, Washington, D. C.

Section on Radiology

The representative to the Scientific Exhibit from the Section on Radiology is RICHARD H. CHAMBERLAIN, Philadelphia.

Diagnosis of Perforated Abdominal Viscus on Supine Films.

EMANUEL MENDELSON, State University of New York College of Medicine, Brooklyn, N. Y.

A New Agent for Preparation of Patients for X-ray Examination of the Abdomen.

MILTON BIRNKRANT, Beth David Hospital, New York.

Significance and Diagnosis of Colonic Polyps.

LEO S. FIGIEL, STEVEN J. FIGIEL, and FRED K. WIETERSEN, Grace Hospital, Detroit.

Combined Retroperitoneal Pneumography and Laminography in the Diagnosis of Midline Abdominal Tumors.

GEORGE T. WOHL and RALPH MYERSON, Veterans Administration Hospital, Philadelphia.

Rotation Cobalt Teletherapy for Cancer: Television-Fluoroscopic Alignment Technique.

HENRY L. JAFFE and STANLEY H. CLARK, Cedars of Lebanon Hospital and University of Southern California School of Medicine, Los Angeles.

Contrast Radiography (Opaque Contrast Mediums).

THEODORE F. HILBISH and EUGENE BRONSTEIN, the Clinical Center, National Institutes of Health, Bethesda, Md.

Clinical Applications of Intraosseous Venography.

FRANZ P. LESSMANN, ROBERT SCHOBINGER VON SCHOWINGEN, ELLIOTT C. LASSER, and PAUL ZUCKERMAN, Roswell Park Memorial Institute, Buffalo.

Preoperative Roentgen Studies in Primary Lung Carcinoma.

LAWRENCE REYNOLDS, WILLIAM M. TUTTLE, HAROLD E. FULTON, and GEORGE F. BOONE, Harper Hospital, Detroit.

Chordoma.

CHARLES M. GREENWALD, THOMAS F. MEANEY, and C. ROBERT HUGHES, Cleveland Clinic, Cleveland.

Selective Segmental Bronchography.

ANDREW MACKAY, ARMAND TREPANIER, and MAURICE R. DUFRESNE, Hospital Notre Dame, Montreal, Canada.

Section on Surgery, General and Abdominal

The representative to the Scientific Exhibit from the Section on Surgery, General and Abdominal is JOHN H. MULHOLLAND, New York.

Prosthetic Restorations in Head and Neck Surgery.

MARTIN J. HEALY JR., BENJAMIN M. HOFFMAN, JAMES A. SUDBOY, HAROLD H. NIEBEL, and MERLIN K. DUVAL, Veterans Administration Hospital, Bronx, N. Y.

Treatment of Gastric Cancer.

GEORGE T. PACK, GORDON P. MCNEER, KATHLEEN E. ROBERTS, DOUGLAS A. SUNDERLAND, LOUIS G. ORTEGA, and HENRY T. RANDALL, Memorial Hospital, New York.

Carcinoma of Colon and Rectum.

RICHARD B. CATTELL, NEIL W. SWINTON, and BENTLEY P. COLCOCK, the Lahey Clinic, Boston.

Postoperative Thromboembolism.

HOWARD S. MADIGAN, HUGH H. HUSSEY, and PHILIP A. CAULFIELD, Georgetown University Medical Center, Washington, D. C.

Carcinoma of the Lung.

ALTON OCHSNER, ROBERT J. SCHRAMEL, JOHN B. BLALOCK, JACK HAROLD KEELING, and JACK A. HALEY, Tulane University School of Medicine and Ochsner Clinic, New Orleans.

Palliation of Esophageal Obstruction due to Carcinoma with a Permanent Intraluminal Tube.

S. A. MACKLER and G. BARD, Chicago Medical School, Cook County and Michael Reese hospitals, Chicago.

The Ulcerogenic Tumor of the Pancreas.

EDWIN H. ELLISON, Ohio State University Health Center, Columbus, Ohio.

Ventricular Septal Defect: Diagnosis and Surgical Treatment.

H. B. BURCHELL, R. O. BRANDENBURG, H. J. C. SWAN, D. E. DONALD, A. J. BRUWER, J. W. DUSHANE, H. G. HARSHBARGER, J. E. EDWARDS, J. W. KIRKLIN, and E. H. WOOD, Mayo Clinic and Mayo Foundation, Rochester, Minn.

Obliterative Arterial Disease of the Lower Extremity—Clinical, Laboratory, and Radiographic Correlations.

JOHN J. CRANLEY and RAYMOND J. KRAUSE, Good Samaritan and Cincinnati General hospitals, Cincinnati.

Hypothermia in Cardiovascular Surgery.

MAX S. SADOVE, ORMAND C. JULIAN, and MYRON J. LEVIN, Veterans Administration Hospital, Hines, Ill.

Blood-Oxygenator.

FRANK GOLLAN, JAMES T. GRACE, and WALTER G. GOBBEL JR., Veterans Administration Hospital and Vanderbilt University Medical School, Nashville, Tenn.

The Tame Assay for the Routine Determination of Plasma Prothrombin: Special Reference to the Control of Anticoagulant Therapy.

JOHN H. OLWIN, PHYLLIS M. ARSCOTT, and J. L. KOPPEL, Presbyterian Hospital, Chicago.

Operation for Coronary Artery Disease.

CLAUDE S. BECK, DAVID S. LEIGHNINGER, and BERNARD L. BROFMAN, University Hospitals of Cleveland, Cleveland.

Operative Cholangiography.

C. ALLEN WALL and S. PATRICK PEARTREE, St. Louis University Hospitals, St. Louis.

The Problem of the Nonadherent Surgical Dressing.

JAMES F. CONNELL JR., WILLIAM PHILIP, FRANK GILBERTSON, and LOUIS M. ROUSSELOT, St. Vincents Hospital, New York.

Parenteral Alimentation.

WILLIAM E. ABBOTT, HARVEY KRIEGER, and STANLEY LEVEY, University Hospitals of Cleveland and Western Reserve University School of Medicine, Cleveland.

The Pathology and Surgery of Parotid Gland Neoplasms.

ROBERT S. TOTTEN, JOHN C. GAISFORD, and DWIGHT C. HANNA, Presbyterian Hospital, Pittsburgh.

The Surgical Management of Regional Enteritis.

HERBERT R. HAWTHORNE, ALFRED S. FROBESE, and PAUL NEMIR JR., Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Controlled Respiration in Surgery and Resuscitation.

ARCHER S. GORDON, CHARLES W. FRYE, and HIRAM T. LANGSTON, University of Illinois College of Medicine and Chicago State Tuberculosis Sanitarium, Chicago.

The Multiple Injury Patient.

ROBERT H. KENNEDY, LESTER BLUM, BENJAMIN A. PAYSON, and BEN F. BRYER, Beekman Downtown Hospital, New York.

Anemia Following Gastrectomy.

H. J. MCCORKLE, DWIGHT H. MURRAY JR., DEAN L. MAWDSLEY, and HAROLD A. HARPER, University of California Medical School, San Francisco.

Variations of Intestinal Peristalsis: A Correlation of Clinical, X-ray, and Pathological Findings.

LEROY H. STAHLGREN and L. KRAEER FERGUSON, Philadelphia.

Tumors of the Hand.

JOSEPH L. POSCH and ROBERT D. LARSEN, City of Detroit Receiving Hospital and Wayne University College of Medicine, Detroit.

Techniques in Abdominal Surgery.

JOHN L. MADDEN, WILLIAM J. MCCANN, and JOHN M. LORÉ JR., St. Clare's Hospital, New York.

Adrenocortical Tumors and Hyperplasia: Diagnosis and Treatment.

JAMES D. HARDY, University of Mississippi Medical Center, Jackson, Miss.

Streptokinase Intramuscularly in the Treatment of Infection and Edema.

JOSEPH M. MILLER, JOHN A. SURMONTE, and MILTON GINSBERG, Veterans Administration Hospital, Fort Howard, Md., and FRANK B. ABLONDI, Lederle Laboratories, Pearl River, N. Y.

Section on Urology

The representative to the Scientific Exhibit from the Section on Urology is MILTON M. COPLAN, Miami, Fla. There will be a general discussion of the exhibits in this Section at 10 a. m. on Tuesday, Wednesday and Thursday. The following urologists will lead the discussions:

EDWARD N. COOK, Rochester, Minn.
ROBERT LICH JR., Louisville, Ky.
REGINALD A. HANCOCK, Pittsburgh.

Demonstration of Technique of Endoscopic Prostatic Surgery.

ROGER W. BARNES, RODERICK D. TURNER, R. THEODORE BERGMAN, and HENRY L. HADLEY, Los Angeles.

Substitute Urinary Bladders: Experimental Work on Dogs.

ALBERT E. GOLDSTEIN, CAFER YILDIRAN, and HANNAH SILBERSTEIN, Hoffberger Urological Research Laboratory, Sinai Hospital, Baltimore.

The Undescended Testis Problem.

NORRIS J. HECKEL, JAMES H. MCDONALD, and JAMES A. CALAMS, University of Illinois College of Medicine and Presbyterian Hospital, Chicago.

The Thul-X—a New Portable Radiographic Unit for Use in Surgery.

DONALD E. BURKE and CHESTER WINTER, University of California Hospital, Los Angeles.

A Modified Method for Handling and Administering Radioactive Gold in Carcinoma of the Prostate.

WILLIAM J. BAKER, EDWIN C. GRAF, EUGENE LUTTERBECK, I. F. HUMMON, D. H. CALLAHAN, and RAYMOND FIRGER, Chicago.

Penile and Scrotal Injuries.

RALPH J. HOLLOWAY, DAVID A. CULP, and W. C. HUFFMAN, University Hospitals, Iowa City, Iowa.

Urethroplasty.

DAVID A. CULP, HANS KRONAWETTER, and RICHARD PORTO, University Hospitals, Iowa City, Iowa.

Reversible Hypertension due to Renal Artery Disease.

EUGENE F. POUTASSE, WILLIAM J. ENGEL, and HARRIET DUSTAN, Cleveland Clinic, Cleveland.

Hydronephrosis, Secondary to Obstruction in Lower Ureter.

MICHAEL K. O'HEERON and JAMES R. FISH, St. Joseph's Hospital, Houston, Texas.

Salicylate Therapy for Recurrent Calcium Urinary Stone.

EDWIN L. PRIEN and BURNHAM S. WALKER, Boston University School of Medicine, Boston.

A Clinical Study of a New Renal Function Test: The Radioactive Diodrast Renogram.

CHESTER C. WINTER and GEORGE V. TAPLIN, Wadsworth Veterans Administration Hospital and University of California at Los Angeles, Los Angeles.

A Bacteriocidal Additive for Pyelographic Mediums.

RUSSELL B. ROTH, ANTHONY F. KAMINSKY, and ELMER HESS, St. Vincent's Hospital, Erie, Pa.

Renal Lymphatics: Experimental Studies.

WILLARD E. GOODWIN and JOSEPH J. KAUFMAN, University of California Medical Center, Los Angeles.

Renal Biopsy.

A. PAGE HARRIS, HAROLD COLLINS, and CHARLES E. HAINES, Vanderbilt University Hospital, Nashville, Tenn.

The Horseshoe Kidney.

THEODORE R. FETTER and N. R. VARANO, Jefferson Medical College Hospital, Philadelphia.

Surgical Techniques of Total Perineal Prostatectomy.

RODERICK D. TURNER and ELMER BELT, University of California School of Medicine at Los Angeles, Los Angeles.

The Urinary Stone Problem.

DONALD W. BRANHAM, JOE E. COLLINS, and W. FRIEDMAN, the University Hospitals and Veterans Hospital, Oklahoma City.

Section on Miscellaneous Topics

The Medical Audit.

ROBERT S. MYERS, American College of Surgeons, Chicago; VERGIL N. SLEE, Pennock Hospital, Hastings, Mich., and ROBERT S. HOFFMANN, Ann Arbor, Mich.

National Board Examinations.

JOHN B. HUBBARD, National Board of Medical Examiners, Philadelphia.

The Preparation of Photographs for Publication.

VERLIN Y. YAMAMOTO, Des Moines, Iowa, Biological Photographic Association, Inc.

Better Medical Writing.

LEE D. VAN ANTWERP, Chicago, HAROLD SWANBERG, Quincy, Ill.; and RICHARD M. HEWITT, Rochester, Minn.; American Medical Writers' Association.

Vitamin B. in Medical Practice.

E. H. STEVENSON and MARY JANE KIBLER, Council on Foods and Nutrition, American Medical Association, Chicago.

Modern Management of the Cleft Lip and Cleft Palate Patient.

WALTER WM. DALITSCH, FREDERICK W. MERRIFIELD, ORION H. STUTEVILLE, HAROLD WESTLAKE, JOHN R. THOMPSON, TOURO M. GRABER, and MORTON S. ROSEN, Northwestern University Cleft Palate Institute, Chicago.

Standard Nomenclature of Diseases and Operations.

ADALINE C. HAYDEN, Standard Nomenclature, American Medical Association, Chicago.

Air-Borne Mold Spores in Seasonal Allergy.

OREN C. DURHAM, Abbott Laboratories, North Chicago, Ill., and DAVID MERKSAMER, Jewish Hospital, Brooklyn, N. Y.

Red Cross Blood Program.

DAVID N. W. GRANT, American National Red Cross, Washington, D. C.

The Epilogue: Autopsies.

PAUL R. STALNAKER, W. W. COULTER, HORACE T. AYNESWORTH, and J. MURRY SMITH, Houston, Texas.

Specific Adaptive Illness.

THERON G. RANDOLPH, Chicago; C. R. AHROON, Bloomington, Ill.; HARRY G. CLARK, Detroit; GEORGE S. FRAUENBERGER, Evanston, Ill.; DONALD S. MITCHELL, Montreal, Canada; RALPH C. ROBERTS, Evanston, Ill.; ROBERT P. WATTERSON, Scottsdale, Ariz.; and HUGO ZOTTER, Danville, Ill.

the A. M. A.

TECHNICAL EXPOSITION

Navy Pier

Chicago, Illinois

June 11-15, 1956

The Technical Exposition will be on the shore end of Navy Pier (on Lake Michigan at Grand Avenue). It will present to the visiting physician just about all that is of value to modern medical practice.

You will find a vast array of the most modern materia medica—truly a medical mart, assembling in one place a complete and varied assortment of the products and services available to today's doctor. It is a rare convenience to find all these materials and the men qualified to present them under one roof.

Much of your time will be devoted to the Section Meetings—that is indeed as it should be. Still, with so much of practical interest to be displayed at the Technical Exposition, one could spend the entire week examining the hundreds of exhibits on Navy Pier. The more generous the portion of time you reserve, the more you will enjoy and profit by visits with the many leaders in pharmaceutical research, diagnostic and therapeutic equipment engineering, medical publishing, and scientific instrumentation, as well as by discussion with the developers of dietary, toiletry, and other adjunctive specialties for your patients' use.

We hope that Chicago will dish up some fine weather . . . the lake front is particularly delightful when it does! But, whatever the weather, you will find comfort on the Pier at a number of spots to be reserved for rest and relaxation—there for your enjoyment and, the exhibits, for your examination, from 8:30 to 5:30 daily, closing at noon on Friday. Representatives of the firms listed on the following pages will be awaiting your visit.

THOS. R. GARDINER
Business Manager and Director of Technical Exhibits

TECHNICAL EXHIBITORS — 105th ANNUAL MEETING

A. C. D. Hospital Specialties, Inc.
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Bauer & Black
Baum, W. A., Co., Inc.
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Becton, Dickinson and Company
Beech-Nut Packing Company
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Best Foods, Inc., The
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Coreco Research Corporation
Corn Products Sales Company
Cream of Wheat Corporation, The
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Davies, Rose & Company, Ltd.
Davis, F. A., Company
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Detecto Scales, Inc.
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Dictaphone Corporation
Dietene Company, The
Dome Chemicals Inc.
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du Pont de Nemours, E. I., and Company, Inc.
Durex Products, Inc.
E & J Manufacturing Company
Eastman Kodak Company
Eaton Laboratories
Edin Company, Inc.
Edison, S. M., Chemical Company
Edison, Thos. A., Inc., Ediphone Division
Edwards, J., & Company
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Foot-So-Port Shoe Company
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Fougera, E., & Company, Inc.
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Keleket X-Ray Corporation
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Lavry's Products, Inc.
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Lederle Laboratories Division, American Cyanamid Company
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Lilly, Eli, & Company
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Riker Laboratories, Inc.
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Robins, A. H., Company, Inc.
Roerig, J. B., & Company
Rorer, William H., Inc.
Ross Laboratories, formerly M & R Laboratories
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Sandoz Pharmaceuticals
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State Medical Journal Advertising Bureau, Inc.
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Thomas, Charles C, Publisher
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Webster, William A., Co., The
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Many of you will notice absence of the exhibit descriptions usually found on these pages. This year we will bring them to you in a most timely, up-to-the-minute form — fresh from the presses as the meeting convenes. You will receive your "Guide to A. M. A. Technical Exhibits" as you register

at NAVY PIER

MEDICAL NEWS

ILLINOIS

Psychiatric Lectures.—In its sixth annual lecture series, "Psychiatric Problems in Medical Practice," the North Shore Health Resort, 225 Sheridan Rd., Winnetka, offers "The Prevention of Iatrogenic Disorders" by Dr. Walter C. Alvarez, lecturer in medicine with the rank of professor emeritus, University of Illinois College of Medicine, Chicago, May 2, 8 p. m., at the health resort.

Mental Health Week.—The week of April 29 through May 5 will be observed as "Mental Health Week in Illinois." On Sunday, week-long "Open House" programs will begin in the state's 11 hospitals for the mentally ill and two schools for the mentally deficient. Climax of the observance will be the eighth annual Illinois Mental Health Dinner in the Grand Ballroom of the Palmer House, Chicago, on Thursday evening when the speaker will be Dr. Francis J. Braceland, president-elect of the American Psychiatric Association and psychiatrist-in-chief of the Hartford (Conn.) Institute of Living. The subject will be "Mental Health and the Community."

Meetings on Cardiovascular Disease.—In its postgraduate program the Illinois Academy of General Practice will present "Diagnosis and Management of the Common Cardiac Arrhythmias" by Dr. James C. Havranck, assistant professor of clinical medicine, Stritch School of Medicine of Loyola University, Chicago, on May 3 in the Winnebago County Medical Society building, Rockford. On May 10 "The Nature of Congestive Heart Failure and Its Treatment" will be considered by Dr. Ernest G. McEwen, associate in medicine, Northwestern University School of Medicine, Chicago, and "Indications for Surgery in Cardiovascular Disease" by Dr. William S. Dye Jr., clinical instructor in surgery, University of Illinois College of Medicine, Chicago.

Symposium on Office Procedures and Clinical Medicine.—The Illinois Academy of General Practice, with the cosponsorship of Lederle Laboratories Division, American Cyanamid Company, will present its Symposium on Office Procedures and Clinical Medicine May 3 at the Pere Marquette Hotel, Peoria. Questions and panel discussion will follow the morning program:

- Differential Diagnosis and Management of Jaundice, Harry Shay, Philadelphia.
- Recognition of Obstetrical and Gynecological Emergencies, William P. Given, New York.
- Early Detection and Management of Behavior Problems, John G. Young, Dallas, Texas.

At the luncheon for doctors and wives, 12:45-2:15 p. m., the speaker will be Dr. John R. Bender, Winston-Salem, N. C. The following program will be offered at 2:30 p. m.:

- Plastic Surgical Principles in Farm, Traffic, and Industrial Accidents, James B. Brown, St. Louis.
- Hormonal Therapy in Office Gynecology, C. Gordon Johnson, New Orleans.
- Medicolegal Problems in General Practice, Russell S. Fisher, Baltimore.

No fee is required for attendance at social or scientific sessions. Six hours of category 1 credit will be allowed by the American Academy of General Practice for attendance at the symposium. Wives of physicians are welcome.

Chicago

Kaplan Memorial Lectureship.—Sir Charles Symonds, London, England, will lecture May 1, 8 p. m., at the John B. Murphy Auditorium, American College of Surgeons, 40 E. Erie St., under the sponsorship of the Chicago Neurological Society and the Leo A. Kaplan Memorial Lectureship of the Phi Delta Epsilon Foundation. His subject will be "Hughlings Jackson's Fifth Factor in the Insanities—Local Dissolution."

Physicians are invited to send to this department items of news of general interest, for example, those relating to society activities, new hospitals, education, and public health. Programs should be received at least three weeks before the date of meeting.

Lectures on Wound Healing.—The Stritch School of Medicine of Loyola University, department of biochemistry, is presenting lectures on The Healing of Wounds: Newer Findings and Concepts, Tuesdays at 11 a. m. in Lecture Hall A, 706 S. Wolcott Ave. Remaining lectures in the series include:

- May 1, Advantages and Disadvantages of Incisions Utilized in Pelvic Surgery, Herbert E. Schmitz, department of obstetrics and gynecology, Stritch School of Medicine of Loyola University.
- May 8, Role of Methionine in Wound Healing During Protein Starvation, Leon Edwards, department of surgery, Harvard Medical School, Boston.
- May 15, Healing of Muscle Tissue, David S. Jones, department of anatomy, Stritch School of Medicine of Loyola University.
- May 22, The Ground Substance of Connective Tissue in Healing Wounds, Hubert R. Catchpole, Ph.D., department of pathology, University of Illinois College of Medicine.

KANSAS

State Medical Meeting at Topeka.—The annual meeting of the Kansas Medical Society will convene at the Municipal Auditorium, Topeka, May 1-3. The address of welcome by Dr. Clyde B. Trees, Topeka, president, Shawnee County Medical Society, will be followed by "Socio-Economic Problems of the A. M. A." by Dr. Dwight H. Murray, Napa, Calif., President-Elect of the American Medical Association. At 10:50 a. m. the program and objectives of the Joint Commission on Accreditation of Hospitals will be presented by Dr. Kenneth B. Babcock, Chicago. The afternoon session will be devoted to a panel discussion "Where Do We Go From Here?" in which Drs. Babcock, Murray, and Donald P. Trees, Wichita, will participate. The Wednesday morning program will consist of the following presentations:

- Gastrointestinal Problems in the Aged, Manual Sklar, Chicago.
- Induction of Labor, William C. Keettel, Iowa City.
- Selection of Operations for Carcinoma of the Midtransverse Colon to Rectum Inclusive, Peter A. Rosi, Chicago.
- Severe Toxic Reaction to Intravenous Contrast Media: Cause and Control, Philip J. Hodes, Philadelphia.

The afternoon session will open with "Physiological Changes in Everyday Anesthesia" by Dr. O. Sidney Orth, Madison, Wis. The day's speakers will participate in a panel discussion, "Acute Abdominal Pain," Wednesday afternoon. The annual banquet is scheduled for 7 p. m. at the Topeka Country Club. The eye, ear, nose, and throat program, which will be presented Tuesday and Wednesday, will have as out-of-state speakers Drs. Lawrence T. Post Jr. and Joseph H. Ogura, St. Louis.

MARYLAND

State Medical Meeting in Baltimore.—The Medical and Chirurgical Faculty of the State of Maryland will hold its 158th annual meeting May 2-4 under the presidency of Dr. William H. F. Warthen, Towson, at the society's headquarters, 1211 Cathedral St., Baltimore. The sessions will open Wednesday at 3 p. m. with a paper, "Present Status of Hypothermia in Surgery and Medicine," by Dr. Robert D. Dripps, Philadelphia. The John M. T. Finney Fund Lecture, "Surgical Treatment of Diseases of the Thyroid Gland (Illustrated)," will then be delivered by Dr. William F. Rienhoff Jr., Baltimore. A panel discussion, "Back Injuries—Their Causes and Sequelae," has been arranged for Wednesday, 8 p. m., by the joint committee on medicolegal problems, of which Dr. Russell S. Fisher, Baltimore, is the chairman for the Medical and Chirurgical Faculty. Dr. Raymond K. Thompson, assistant professor of neurological surgery, University of Maryland School of Medicine, Baltimore, will serve as moderator, with the following participants: Dr. George E. Bennett, adjunct professor emeritus of orthopedic surgery; Dr. Harry F. Klinefelter Jr., assistant professor of medicine, Johns Hopkins University School of Medicine, Baltimore; and Mr. Walter V. Harrison, member of the bar. Round-table luncheons (24) have been scheduled for Thursday. Thursday afternoon the Harvey Grant Beck Memorial Lecture, "Current Views on Certain Aspects of Management in Cardiac Infarction (Illustrated)," will be delivered by Dr. Robert L. Levy, New York. Dr. Leon H. Hetherington, Baltimore, chief, bureau

of tuberculosis, Maryland State Department of Health, will moderate a panel discussion, "The Epidemiology and Modern Concepts in the Management of Tuberculosis" at 3:30 p. m. Among the participants will be Dr. David A. Cooper, professor of clinical medicine, University of Pennsylvania School of Medicine, Philadelphia. The Baltimore City Medical Society will be host at cocktails Thursday, 6 p. m., for guests attending the presidential dinner at 7 p. m. Dr. Warthen will preside at a general open meeting, 8:15 p. m., and will deliver the presidential address, "The Practice of Preventive Medicine." An illustrated paper, "Problems Involved in Medical Management of Disaster," will be read by Col. Joseph R. Shaeffer, chief surgical consultant, Office of the Surgeon General, Department of the Army, Washington, D. C. Members are invited to attend the meeting of the House of Delegates Friday morning. The afternoon session will open with "Water Intoxication in Common Problems of Pediatrics and Surgery," by Dr. Robert E. Cooke, New Haven, Conn. The women's auxiliary will meet concurrently. The women's auxiliary to the Baltimore City Medical Society will sponsor the Medical and Chirurgical Faculty Ball, Friday, 9:30 p. m.

MICHIGAN

Annual County Medical Clinic.—The 28th annual May Clinic will be sponsored by the Ingham County Medical Society May 3 at the Hotel Olds in Lansing. The following program will be presented at 2 p. m.:

The Patient with Headache, Perry S. MacNeal, Philadelphia.
Obstruction of the Gastrointestinal Tract of the Infant and Newborn, Egbert H. Fell, Chicago.
Psychosomatic Aspects of Gynecology, Mary E. Giffin, Rochester, Minn.
Urological Aspects of Hypertension, William J. Engel, Cleveland.

A social hour, 5:15 p. m., will precede the subscription dinner, 6:30 p. m., at which "Mechanisms of Hypertension" will be discussed by Dr. Irvine H. Page, Cleveland, president, American Heart Association, and director of research, Cleveland Clinic Foundation, Cleveland.

NEW MEXICO

State Medical Meeting in Roswell.—The 74th annual session of the New Mexico Medical Society will be held at the Roswell Senior High School, 400 W. Hobbs St., Roswell, May 2-4. Chairman of the opening session will be Dr. Earl L. Malone, Roswell, president. After greetings by Dr. Ernest W. Lander, Roswell, president of the Chavez County Medical Society, Dr. Stuart W. Adler, Albuquerque, president-elect of the state medical society, will deliver the inaugural address, "The Do-It-Yourself Syndrome." Guest speakers and their first presentations include:

Biologic Patterns in Human Cancer, Ian G. Macdonald, Los Angeles.
Hodgkin's Disease, with Emphasis on the Mechanism of Death, Capt. Vernon E. Mariens, M.C., U.S.N.
Spine Fusion, Stressing Indications, Dana M. Street, Memphis, Tenn.
Radiological Considerations of Gastrointestinal Bleeding, Robert D. Moreton, Fort Worth, Texas.
Hysterectomy, Conrad G. Collins, New Orleans.
Peripheral Vascular Disease, Morris J. Fogelman, Dallas, Texas.
Treatment of Myocardial Infarction, Carleton B. Chapman, Dallas, Texas.
Outpatient Management of Hypertension, John H. Moyer, Houston, Texas.
Rheumatic Fever as a Diagnostic Problem in Subtropical Climate, Forrest H. Adams, Los Angeles.

Dr. Collins will moderate a panel on acute anuria, and Dr. Moyer will be moderator for a panel on steroids. All guest speakers will participate on the panels. Medical and surgical round-table luncheons are scheduled for Thursday and Friday. Wednesday evening has been set aside for a stag smoker and buffet at the Roswell Country Club and Thursday for the annual dinner-dance at the Officers' Club, Walker Air Force Base. All physicians who are members of their respective state medical societies are cordially invited to attend the annual session. The women's auxiliary will meet concurrently.

NEW YORK

Society News.—At its scientific session, May 1, 9 p. m., in the Kings County Medical Society Building, 1313 Bedford Ave., Brooklyn, the society's section on allergy will present "Modern Concepts of Allergy in Children" by Dr. M. Murray Peshkin, clinical professor of medicine and pediatrics (allergy), Albert Einstein College of Medicine. Dr. Bela Schick, professor of pediatrics at the college, will be the discusser. Members of the medical profession are cordially invited.——On May 10 Dr. Peshkin will discuss "Newer Concepts in the Treatment of Allergy in General Practice" before the Ridgeboro Medical Society, which will meet at 9 p. m. in the Jewish War Veterans Building, 8721 Fourth Ave., Brooklyn.

New York City

Society News.—Philip Person, D.D.S., chief, Dental Research, Veterans Administration Hospital, Brooklyn, and associate professor of biochemistry and physiology, Rutgers University, New Brunswick, N. J., will read a paper, "Clinical Aspects of the Intermediary Metabolism of Oral Tissues," at the monthly conference of the New York Institute of Clinical Oral Pathology, 8:30 p. m., April 30, in the New York Academy of Medicine Building.

Symposium on Speech Disorders.—On April 28 the National Hospital for Speech Disorders will present a symposium, "Problems in Human Communication." Admission for the daytime scientific sessions is by invitation and is limited to individuals identified with scientific research or achievement in medicine, education, and allied endeavors. The evening program will not be limited to professional persons. The evening panel, "Uses and Abuses of Mass Communication Media," will be moderated by Miss Martha Rountree, formerly producer-moderator of the radio-television program, "Meet the Press." Dr. Lynwood Heaver is director of the hospital.

RHODE ISLAND

State Medical Meeting in Providence.—The 145th annual meeting of the Rhode Island Medical Society will convene at the headquarters of the society, the Rhode Island Medical Society Library, Providence, May 1-3, under the presidency of Dr. Frank B. Cutts, Providence. The sessions will open Tuesday at 2 p. m. with a forum, "Help for the Hopeless," over which Dr. Samuel D. Clark, Bristol, president, Rhode Island chapter, American Academy of General Practice, will preside. The following presentations will also be made Tuesday afternoon:

The Doomed Infant and Child, Clement A. Smith, Boston.
He Was in the Prime of Life, Earle M. Chapman, Boston.
Making a Graceful Exit, Peter P. Chase, Providence.

Wednesday afternoon "Recent Advances in Plastic Surgery" by Dr. Richard P. Sexton, Providence, will be followed by a paper on pediatric x-ray by Dr. Edward B. D. Neuhauser, Boston, and "Carcinoma-in-Situ" by Dr. Benjamin Castleman, Boston. The Caleb Fiske Prize Dissertation, "The Radioiron Turnover Test in Clinical Medicine," by Dr. R. Kenneth Loeffler, Houston, Texas, will precede the presidential address, which will be given at 4:30 p. m. At 8:30 p. m. "Medical Rehabilitation in a General Hospital" will be discussed by Dr. Arthur L. Watkins, Boston, after which the Charles V. Chapin Oration, "Advances in the Diagnosis and Treatment of Adrenal Disorders," will be delivered by Dr. George W. Thorn, Boston. The following program will be presented Thursday afternoon:

Hemolysis in the Anemias, Frank H. Gardner, Boston.
Problems in the Treatment of Adults with Patent Ductus Arteriosus, George H. Humphreys II, New York.
Diagnosis of Atrial Septal Defect and the Operative Result, S. Gilbert Blount Jr., Denver.
Early Recognition and Treatment of Liver Disorders, Daniel S. Ellis, Brookline, Mass.

The address at the annual dinner will be given by John O. Pastore, Providence, U. S. Senator from Rhode Island.

WASHINGTON

Surgical Club Meeting.—The annual meeting of the Tacoma Surgical Club will be held May 5 at the Tacoma General Hospital. The morning program will consist of anatomic and surgical demonstrations and discussions. Scientific papers will be presented during the afternoon. The evening session will convene at the Winthrop Hotel. Guest speakers will be Dr. John M. Waugh, professor of surgery, University of Minnesota Graduate School, Minneapolis, and Dr. Robert J. Johnson, associate

professor of anatomy, University of Washington School of Medicine, Seattle. Information may be obtained from Dr. Edward R. Anderson, Secretary, Tacoma Surgical Club, 107 Medical Arts Bldg., Tacoma.

WISCONSIN

State Medical Meeting in Milwaukee.—The State Medical Society of Wisconsin will hold its annual meeting May 1-3 at the Milwaukee Auditorium and the Schroeder Hotel under the presidency of Dr. Ervin L. Bernhart, Milwaukee. Out-of-state speakers for the general program will include:

William B. Kountz, St. Louis, Drugs in Relation to Geriatrics of Special Interest to General Practitioners.
Herbert Rattner, Chicago, What's New and What's True in What's New in Dermatology.
O. Randolph Batson, Nashville, Tenn., Acute Hepatitis in Infancy and Childhood.
Frederick A. Coller, Ann Arbor, Mich., Surgery of the Gallbladder and the Bile Ducts.
Edward A. Gall, Cincinnati, Aids in the Diagnosis of Liver Disease.
Grantley W. Taylor, Boston, Malignant Melanoma.
Gene H. Stollerman, Chicago, Prevention of Rheumatic Fever—General Principles and Methods.
Milton M. Coplan, Miami, Fla., Ureteral and Bladder Injuries Following Pelvic and Colon Surgery.
Vernon Kinross-Wright, Houston, Texas, Uses and Limitations of the Newer Drugs in the Treatment of Nervous Conditions.

A general practice day, open to all physicians, will be sponsored Tuesday by the Wisconsin Academy of General Practice. A tumor clinic (Kodachromes), presented before the general assembly at 4:15 p. m. Tuesday, will be moderated by Dr. Sture A. M. Johnson, Madison, and will have as one of its participants Dr. Robert Kierland, Rochester, Minn. All society members and their wives are invited to an informal evening of entertainment (Gemütlichkeit Night) at the Schroeder Hotel, Tuesday, 8:30 p. m. Wednesday afternoon a special program on obstetrics and gynecology will open with a panel discussion and will close with "Highlights of Female Genital Cancer" by Dr. William F. Mengert, Chicago. A special program on radiology will be opened by Dr. M. M. Figley, Ann Arbor, Mich., who will discuss "Radiologic Evaluation of Mitral Valve Disease," after which "Pathologically Proven Mediastinal Masses" will be presented by James G. Bulgrin, Capt., M.C., U.S.N., Great Lakes, Ill. A special program on internal medicine, Thursday afternoon, will include "The Management of Chronic Ulcerative Colitis" by Dr. Joseph B. Kirsner, Chicago, and will conclude with a round table on coronary disease. Simultaneously there will be a special program on anesthesia, which will include "Fundamental Errors in Anesthesia" by Dr. Stuart C. Cullen, Iowa City, and "Respiratory Emergencies" by Dr. Joseph J. Buckley, Minneapolis, both of whom will participate in a closing discussion, "Anesthesia in Relation to Cesarean Section." A special program of the section on ophthalmology and otolaryngology will include a paper by Dr. Alson E. Braley, Iowa City (topic to be announced), and "The Operation for Stapes Mobilization" by Dr. John R. Lindsay, Chicago. All society members and their ladies are invited to the reception for Dr. and Mrs. Bernhart, Thursday, 5:30 p. m., which will honor the conclusion of Dr. Bernhart's term as president. At the annual dinner, 7 p. m., Dr. Lien O. Simenstad, Osceola, will assume the presidency.

GENERAL

Meeting of Inhalation Therapists.—During the Tri-State Hospital Meeting April 30-May 3, the American Association of Inhalation Therapists section will present "Humidity Control in Inhalation Therapy" by Dr. Joseph B. Miller, Mobile, Ala., Monday, 1:30 p. m. On Tuesday at the same time "Postoperative Cardiopulmonary Collapse" will be discussed by Dr. Stuart C. Cullen, Iowa City. The meetings will be held at the Palmer House, Chicago.

Joint Meeting of Pathologists.—The Northwestern Region, College of American Pathologists, and the Pacific Northwest Society of Pathologists will hold a meeting, May 4-5, in the Main Auditorium, Health Science Building, University of Washington, Seattle. At 1:30 p. m. Dr. Elson B. Helwig, chief of pathology, Armed Forces Institute of Pathology, Washington, D. C., will discuss "Precancerous Dermatoses." Cocktails, 6:30-7:30 p. m., will precede dinner at the Seattle Yacht Club.

Gastroenterologists Meet in Atlantic City.—The 57th annual meeting of the American Gastroenterological Association is scheduled for April 27-28 at the Hotel Claridge, Atlantic City, N. J. During the sessions 29 papers will be presented and 31 read by title. The presidential address will be delivered Saturday at 9 a. m. by Dr. Robert Elman, St. Louis. The Saturday afternoon session will open with the second annual Memorial Lecture, "Neural Basis of Hunger, Appetite, and Satiety," by Dr. John R. Brobeck, Philadelphia. At the banquet on Saturday (cocktails, 7 p. m.; banquet, 8 p. m.), the Julius Friedenwald medal will be presented to Dr. Donald C. Balfour, Rochester, Minn.

Annual Meeting on Clinical Investigation.—The 48th annual meeting of the American Society for Clinical Investigation will be held at the Steel Pier Theater, Atlantic City, N. J., April 30. In all, 28 papers will be read. Single-author presentations by invitation will include:

Oxidative Phosphorylation in the Hepatic Mitochondria of Normal, Diabetic, and Insulin Treated Cats, John W. Vester, Philadelphia.
Influence of the Metabolic State of Tubercle Bacilli upon the Action of Isoniazid "in Vitro," Dieter Koch-Weser, Chicago.
Studies on the Persistence of Staphylococcal Bacteremia in Rabbits, David E. Rogers, New York.
Serum Dihydroxy-Trihydroxy Bile Acid Ratio in Liver and Biliary Tract Disease, James B. Carey Jr., Minneapolis.

Regional Meeting of Surgeons.—The United States Section of the International College of Surgeons will hold a southeastern regional meeting in the Read House, Chattanooga, Tenn., April 30-May 1. Dr. Max Thorek, Chicago, secretary-general of the college, and Dr. Ross T. McIntire, Chicago, executive director, will be the banquet speakers on Monday. The luncheon that day will be addressed by Dr. Arnold S. Jackson, Madison, Wis., president of the United States Section, and Dr. McIntire. Panels on gallbladder disease, surgery of the thyroid, and surgery of the stomach will be moderated by Dr. Jackson, Dr. Moses Behrend, Philadelphia, and Dr. Claude J. Hunt, Kansas City, Mo. For details, write Dr. William G. Stephenson, 546 McCallie Ave., Chattanooga 2, Tenn.

Meeting of Goiter Association.—The annual meeting of the American Goiter Association will convene at the Drake Hotel, Chicago, May 3-5. In all, 39 presentations will be read. Single-author presentations include:

Hormonal Treatment of Carcinoma of the Thyroid, Colin G. Thomas Jr., Chapel Hill, N. C.
Malignant Exophthalmos, Alson E. Braley, Iowa City.
Levator Spasm a Factor in Exophthalmos and Its Correction, Robert E. Moran, Washington, D. C.
Effect of Anesthesia and Thyroid Surgery on Serum Levels of Radioactive Protein Bound Iodine Levels, Jerrold D. Hydovitz, Philadelphia.

The Van Meter Prize Essay will be read at 8:30 a. m. Friday. The presidential address, "The Thyroidologist and Beckoning Frontiers," will be delivered at 2 p. m. The sessions will close Saturday noon with "A Study of One Thousand Cases of Thyroid Surgery. The Complications and Implications" by Drs. Warren H. Cole, Chicago, and Edson F. Fowler, Evanston, Ill.

Meeting of Anesthesiologists.—The New England Society of Anesthesiologists will meet in Boston, May 4. All members are cordially invited to observe the morning operative schedule at any of the Boston hospitals that have teaching programs for anesthesia. Afternoon and evening sessions will be held at the Smith House, 500 Memorial Dr., Cambridge, Mass. The afternoon session will consist of "Newer Concepts Concerning Depth of Anesthesia" by Dr. Philip D. Woodbridge, Greenfield, Mass., followed by "The Role of Electronics in the Study of Flight Physiology" by Dr. John Abajian, Burlington, Vt., and "The Role of Hypnosis in Preanesthetic Management" by Max H. Jacobs, D.M.D., Boston. A cocktail hour, 5-6 p. m., will precede dinner ($4 per person, including tax and gratuities). At 8 p. m. "Recent Developments in the Clinical Use of Radioisotopes with Particular Reference to Their Use in Anesthesiology" will be discussed by Mr. James C. Searles, field representative, Department of Radio-Pharmaceuticals, Abbott Laboratories, Chicago, under the direction of Donalee Tabern, Ph.D.

Bacteriologists Meet in Houston.—The Society of American Bacteriologists will be the guests of the Texas bacteriologists during the 56th general meeting, April 29-May 3, at the Shamrock Hilton Hotel, Houston, Texas. The presidential ad-

dress will be delivered by Charles A. Stuart, Ph.D., Providence, R. I., at a general session of all divisions Thursday morning. At the general session that will open the convention a special lecture, "Highlights of Microbiology in Texas," will be delivered by Dr. Henry A. Holle, Austin, commissioner of health, state of Texas. There will be a smoker at 9 p. m. On Monday evening symposiums will be presented on (1) The Teaching of Microbiology; (2) Petroleum Microbiology; and (3) Microbial Amino Acid Metabolism. Tuesday evening there will be symposiums on (1) Enterobacteriaceae of Medical Significance: Isolation, Identification, and Pathogenic Potentialities and (2) Industrial Fermentations. Scientific motion pictures will also be presented that evening. President and Mrs. Stuart will be guests of honor at a reception and barbecue Wednesday evening at the Rocking R Ranch. Buses will leave the hotel at 5 p. m. The following symposiums have been scheduled for Thursday afternoon: Cellular Organization in Relation to Function; Problems in Taxonomy; Analytical Microbiology; and New Aspects of Water Bacteriology.

Annual Medical Golf Tournament.—The American Medical Golfing Association will hold its 40th annual tournament June 11 at the Evanston Country Club, Evanston, Ill. Eighteen-hole competition will be the basis for the awarding of prizes. Drs. John H. Pribble and Thomas D. Hall, Chicago, are co-chairmen of the tournament. Tournament play will start at 8 a. m. Players may tee off up to 2 p. m. Buffet luncheon (12 noon to 2 p. m.), banquet (7 p. m.), and green fees are included in the cost of the day's activities. All male members of the American Medical Association are eligible to join. Registration cards may be obtained through Bob Elwell, 3101 Collingwood Blvd., Toledo 10, Ohio. Participants are requested to present a certified home club handicap or accept a handicap set by the association's handicap committee. New golfers are urged to attend and will have ample opportunity under a handicap system to win prizes. A member absent from the banquet will forfeit his opportunity for a prize or championship. A Greyhound bus will leave the Conrad Hilton Hotel, Chicago, for the club at 7:30 a. m., making stops at other hotels. Officers of the American Medical Golfing Association include Dr. Baxter H. Timberlake, Atlantic City, N. J., president; Dr. Joseph E. Corr, New York, president-elect; Drs. Paul S. Wayne, San Francisco, and James C. McLaughlin, Philadelphia, vice-presidents; and Dr. D. H. Houston, Seattle, past-president and permanent chairman of the advisory committee.

Psychiatric Meetings in Chicago.—The 112th annual meeting of the American Psychiatric Association will convene at the Morrison Hotel, Chicago, April 30-May 4, under the presidency of Dr. R. Finley Gayle Jr., Richmond, Va. Response to the presidential address will be made by Dr. Francis J. Braceland, Hartford, Conn., president-elect of the association. On Tuesday at 10:45 a. m. the Academic Lecture, "The Great Psychiatric Revolution," will be delivered by Dr. Percival Bailey, Chicago. The following round-table dinner meetings will be held Tuesday, 7 p. m.: Your Patient and His Job; Research Study in Homosexuality; Roles in Community Mental Health; Psychobiology 1956; What Is Effective in the Therapeutic Process; The Relation of Cultural Ethics to Society; and Lay vs. Medical Administration in Psychiatric Hospitals. The following round-table meetings at 8 p. m. (no dinner) will also be presented on Tuesday evening: Psychiatric Education During the Internship—Rotating and Straight; Clinical Studies on the Ward Care of Patients; Drug Therapies; Chronic Mental Illness—Prospectus for Prevention and Treatment; and Changing Indications for Electrotherapy. Wednesday at 10:30 a. m. there will be a theoretical symposium on "Recent Progress in Genetics and Its Implications for Psychiatric Theory." All members and guests are cordially invited to attend the Dutch-treat cocktail party Wednesday, 5-7 p. m., which will precede the annual dinner.——The American Psychoanalytic Association, which will hold its annual meeting April 27-29, will hold a joint meeting with the section on psychoanalysis of the American Psychiatric Association Monday afternoon, at which remarks will be made by Dr. Gayle and by Dr. William G. Barrett, San Francisco, president of the psychoanalytic association, and a paper, "Psychiatry Before and After Freud," will be presented by Dr. Ernest Jones, Midhurst, Sussex, England, honorary president, International Psychoanalytical Association. The American Psychoanalytic Association will devote its plenary session Friday at 9:15-10:15 a. m. to the formal opening of the Freud centenary celebration, at which Dr. Jones will be introduced. The remainder of the day will be devoted to the following discussions: Acting Out and Its Relations to Disturbances in Impulse Control; Indications and Goals of Child Analysis as Compared with Child Psychotherapy; and Preoedipal Factors in Neurosogenesis. During this time (10:30 a. m.-4:30 p. m.) brief communications will be read and discussed.

EXAMINATIONS AND LICENSURE

EXAMINING BOARDS IN SPECIALTIES

AMERICAN BOARD OF ANESTHESIOLOGY: *Written.* Various locations in the United States and Canada, July 20. Final date for filing application was Jan. 20. Sec., Dr. C. B. Hickcox, 80 Seymour St., Hartford 15, Conn.

AMERICAN BOARD OF DERMATOLOGY AND SYPHILOGY. *Written.* Various centers, July 26. *Oral.* St. Louis, Oct. 12-15. Final date for filing applications was April 1. Sec., Dr. B. M. Kesten, One Haven Ave., New York 32.

AMERICAN BOARD OF INTERNAL MEDICINE: *Written,* Oct. 15, 1956. Final date for filing application is May 1. *Oral Examinations in 1956,* Chicago, June 7-9. Final date for filing application for these three oral examinations was Jan. 3. New York City, Sept. 21-25. Final date for filing application was April 1. *Cardiovascular Disease.* Chicago, June 6. The number of candidates is limited to 24 and the final date for filing applications was Apr. 2. Exec. Sec., Dr. William A. Werrell, 1 West Main St., Madison 3, Wis.

AMERICAN BOARD OF NEUROLOGICAL SURGERY: St. Louis, May 3-5. Sec., Dr. Leonard T. Furlow, 660 South Kingshighway, St. Louis.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY: *Oral and Pathological Examinations. Part II.* Chicago, May 11-20, 1956. *Part I.* Applications now being accepted. Final date for filing applications is Oct. 1. Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6.

AMERICAN BOARD OF OPHTHALMOLOGY: *Practical Examination.* San Francisco, June 18-21, St. Louis, Oct. 20-24. *Written.* Jan. 21, 1957. Applications must be filed before July 1, 1956. Sec., Dr. Merrill J. King, Box 236, Cape Cottage Branch, Portland 9, Maine.

AMERICAN BOARD OF ORTHOPAEDIC SURGERY: *Part I. Oral and written.* Various centers, April, 1956. Final date for filing application was Nov. 30. *Oral. Part II.* Chicago, January 1957. Final date for filing application is Aug. 15. Sec., Dr. Sam W. Banks, 116 South Michigan Ave., Chicago 3.

AMERICAN BOARD OF OTOLARYNGOLOGY. *Oral.* Montreal, Canada, May 6-10. Sec., Dr. Dean M. Lierle, University Hospitals, Iowa City.

AMERICAN BOARD OF PATHOLOGY: *Pathologic Anatomy and Clinical Pathology.* Boston, April 18-20. Final date for filing application was March 15. Sec., Dr. Edward B. Smith, 1040 W. Michigan St., Indianapolis 7.

AMERICAN BOARD OF PEDIATRICS: *Oral, Part II.* Atlantic City, May 3-5; Cincinnati, June 8-10; New York City, Oct. 12-14, and San Francisco, Dec. 7-9. Sec., Dr. John McK. Mitchell, 6 Cushman Road, Rosemont, Pa.

AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION. *Parts I and II.* Chicago, June 16-17. Sec., Dr. Earl C. Elkins, 200 First St., S. W., Rochester, Minn.

AMERICAN BOARD OF PLASTIC SURGERY. *Entire Examination.* Buffalo, May 13-15. Final date for filing case reports was Jan. 1. Corres. Sec., Mrs. Estelle E. Hillerich, 4647 Pershing Ave., St. Louis 8.

AMERICAN BOARD OF PROCTOLOGY: *Part I.* Philadelphia, May 5. Final date for filing application was March 15. Sec., Dr. Stuart T. Ross, 520 Franklin Ave., Garden City, N. Y.

AMERICAN BOARD OF RADIOLOGY: Chicago, June 5-9. Final date for filing applications was Jan. 1.; Los Angeles, Sept. 30-Oct. 4. Final date for filing applications is June 1. Sec., Dr. B. R. Kirklin, Kahler Hotel Bldg., Rochester, Minn.

AMERICAN BOARD OF SURGERY: *Part II.* Boston, May 14-15 and Philadelphia, June 4-5. Sec., Dr. John B. Flick, 255 S. Fifteenth St., Philadelphia.

AMERICAN BOARD OF UROLOGY: February 1957. Sec., Dr. William Niles Wishard, 1711 N. Capitol Ave., Indianapolis 7.

BOARD OF THORACIC SURGERY. *Written.* Various centers throughout the country, September. Final date for filing application is July 1. Sec., Dr. William M. Tuttle, 1151 Taylor Ave., Detroit 2.

GOVERNMENT SERVICES

AIR FORCE

Graduates of School of Aviation Medicine.—Col. John R. McGraw, acting commandant of the Air Force School of Aviation Medicine since the death of Brig. Gen. Edward J. Kendricks, in addressing a class of 90 medical officers of the Air Force and Army and from nine other nations at Randolph Air Force Base, April 5, said:

"The 16 graduates from abroad in this class come to more than the entire list of those who attended the School in its first 23 years. Up to the start of World War II we had graduated only 13 surgeons of other lands, and four of these were from the Philippines, at that time a possession of the United States.

"In the decade since the War, we have extended our roster of graduates in other countries to 209, and they are advancing the techniques of aviation medicine in 40 nations outside the orbit of the Soviet Union, besides our own."

The class graduated April 5 was the 41st since the end of World War II and the 118th since the founding of the School of Aviation Medicine in 1918. It brought the graduates of the course in its 38 years of existence to a total of 8,013.

ARMY

Water Fluoridation at Army Posts.—Fluoridation of drinking water at 21 Army posts in the United States, Alaska, Hawaii, and Puerto Rico has been approved to date, it was announced by Major Gen. Silas B. Hays, the surgeon general of the Army. The fluoridation of drinking water at Army installations lacking the natural fluorine necessary for oral health was approved by the Army Medical Service in July, 1954. Through the cooperation of the Corps of Engineers, the fluoridation equipment and engineering skill required to install the process are assured. Each military post must obtain the approval of the surgeon general of the Army and the endorsement of the Corps of Engineers.

Installation requests for fluoridation are submitted to the surgeon general accompanied by a report on the natural fluoride content of the water on the post and a statement of the number of persons to benefit from the procedure. Enclosed with the request should be a diagram of the water supply system showing the sources of the water, the fluoride content and annual flow of each source, the treatment plants, distribution lines, dependent housing area, and the point or points at which it is proposed to introduce the fluorides.

The installation also should present to the surgeon general an outline of the steps to be taken to insure periodic medical inspection of the process and to establish safety rules for the operating personnel. The age of the population at an installation is important in determining the priority for setting up the fluoridation process. A census of the number of persons under 12 years of age, the number between 12 and 16, and those between 16 and 20 years living on the installation must be a part of the application for fluoridation.

In commenting on the matter, Major Gen. Oscar P. Snyder, chief of the Army Dental Corps, pointed out that in the fall of 1953 the Army Dental Corps requested an opinion from the committee on dentistry of the National Research Council as to the desirability of fluoridating the water supply at Army posts. The following statement was received from the council: "The Committee on Dentistry believes that there is sufficient scientific evidence of the merits of fluoridation of public water supply to justify its use on military posts whenever feasible and especially where there is a child population in residence."

In addition to American Dental Association and National Research Council approval, Army policy on fluoridation is based on recommendations made by the American Medical Association, United States Public Health Service, and other scientific groups. Regulations now in effect to control the granting of requests for fluoridation have a global application. The program is expanding and no change in Army policy is anticipated in the foreseeable future.

Military Preventive Medicine Course.—To meet the demand for preventive medicine officers within the armed services, the Army has completed initial plans for training career men in this field. The program envisions offering to a limited number of young officers six years of training and experience, which will fulfill the requirements for examination by the American Board of Preventive Medicine. The proposal includes one year's formal training in preventive medicine, followed by two years' residency training in preventive medicine and public health, and three years' assignment to duties acceptable by the American Board of Preventive Medicine. Following this, some graduates will be able to remain in preventive medicine or in the field of medical staff and medical administration work (with future attendance at appropriate service schools) or to go into research, especially in epidemiology.

The course includes the organization, administration, and practices involved in public health programs; vital statistics; microbiology; immunology; and other related subjects. It is 48 weeks in length and includes academic studies and a 10-day field trip to Puerto Rico. Individuals desiring to attend this course are urged to submit an application in letter form direct to the Surgeon General, Department of the Army, Washington 25, D. C., ATTN: Personnel Division. Applications should reach this office at the earliest possible date.

NAVY

Research Training Program for Students.—Sixty-day active duty for training at Naval Medical Research Activities is available to medical students commissioned as ensigns, 1955, U. S. Naval Reserve, who have successfully completed their first year of medical school. A part of the training will be spent in each research department, and the trainee will serve as an assistant in actual laboratory research on one specific project under way at that time, thus, not only is provided summer employment for undergraduate students, but orientation and indoctrination into medical research is offered, as well as on-the-job training commensurate with the individual's professional attainments. Full pay and allowances are authorized.

This program, which begins July 1 each year and ends June 30 of the subsequent year, has been established at Naval Medical Research Activities at eight cities throughout the United States. Eligible and interested officers should make application to their district commandant (medical reserve program officer) at the earliest practicable date.

Guest Lecturer.—Dr. Esmond R. Long, formerly director, Henry Phipps Institute at the University of Pennsylvania, lectured at the National Naval Medical Center, Bethesda, Md., April 26, on the "History of the Chemotherapy of Tuberculosis."

PUBLIC HEALTH SERVICE

New Plan for Processing Research Grants.—The Public Health Service has announced a new procedure to expedite the processing of research grant applications for requests that do not exceed $2,000 plus indirect costs and that do not ask support for more than one year. Such applications will be accepted and processed on receipt and are not, therefore, subject to the usual deadlines for submission prior to review. Council recommendations can be expected on these applications within one to four months from the time of submission. These procedures do not apply for requests for supplements to existing grants. Address applications and requests for forms or additional information to the Division of Research Grants, National Institutes of Health, Bethesda 14, Md.

DEATHS

Bird, W. Edwin ✦ Wilmington, Del.; born in Barton, Md., in 1886; Johns Hopkins University School of Medicine, Baltimore, 1911; since 1948 executive secretary of the Medical Society of Delaware, of which he was president in 1947; past-president and secretary of the New Castle County Medical Society; formerly vice-president of the Federation of State Medical Examining Boards and on the executive committee; for many years a member of the state board of medical examiners; trustee of Group Hospital Service from June, 1935, until December, 1952; since February, 1947, Blue Cross medical consultant; fellow of the American College of Surgeons, of which he was a member of the board of governors; specialist certified by the American Board of Surgery; during World War I draft board medical adviser; honorary surgeon, formerly consultant surgeon, and attending surgeon at the Wilmington General Hospital; since 1916 editor of the *Delaware State Medical Journal*; died in the Delaware Hospital March 17, aged 70, of ruptured dissecting aneurysm of the aorta and arteriosclerosis.

Raymond, Albert Orville ✦ Worcester, Mass.; born in Brockton Jan. 25, 1889; Tufts College Medical School, Boston, 1914; interned at the House of Mercy Hospital in Pittsfield; interned at the Worcester City Hospital, where he was appointed on the staff in 1921, in 1936 became senior obstetrician, and in 1950 consulting obstetrician; on the staff of the Fairlawn Hospital; served overseas with the Royal Medical Corps and later in the U. S. Army during World War I; after the armistice served with the British Army of Occupation in Cologne and later with the American Army of Occupation near Coblenz; awarded the British Military Cross for meritorious service rendered the allied cause, and the British Army Officers' Front Line medal; died in the City Hospital Dec. 13, aged 66, of coronary thrombosis.

Carter, Fred Gay, Shaker Heights, Ohio; born in Viola, Wis., Feb. 28, 1888; Johns Hopkins University School of Medicine, Baltimore, 1920; past-president of the American Hospital Association and in 1952 received its award of merit; past-president of the Minnesota Hospital Association, American College of Hospital Administrators, and the Ohio Hospital Association; served during World War I; formerly superintendent of Ancker Hospital in St. Paul and the Christ Hospital in Cincinnati; from 1939 to 1952 superintendent of St. Luke's Hospital in Cleveland, where he was vice-president in charge of development from 1952 to 1954; died Feb. 19, aged 67, of acute myocardial infarction.

Allen, John Frank Waite, Ithaca, N. Y.; College of Physicians and Surgeons, medical department of Columbia College, New York City, 1894; an associate member of the American Medical Association; served during World War I; honorary member of staff, Tompkins County Memorial Hospital; died in the Conklin Sanitarium Jan. 27, aged 85, of arteriosclerosis.

Barrett, James Willis, Jr. ✦ Independence, Iowa; the Hahnemann Medical College and Hospital, Chicago, 1919; on the staff of the People's Hospital; died Jan. 23, aged 64, of coronary thrombosis.

Benedict, Augustus Palmer ✦ Fair Haven, Vt.; Harvard Medical School, Boston, 1923; health officer and school physician; on the courtesy staff of the Rutland (Vt.) Hospital, where he died Jan. 10, aged 60, of coronary thrombosis.

Bennett, Burrell L. ✦ Van Buren, Ark.; Arkansas Industrial University Medical Department, Little Rock, 1892; past-president of the Crawford County Medical Society; died Dec. 2, aged 89, of cerebral sclerosis.

Bishop, George Creed ✦ St. Bernard, Ohio; University of Cincinnati College of Medicine, 1924; interned at the Good Samaritan Hospital, Cincinnati, where he was past-president of the staff and where he died Jan. 15, aged 54, of coronary occlusion.

✦ Indicates Member of the American Medical Association.

Brobst, John William ✦ Columbus, Ohio; Starling Medical College, Columbus, 1902; served during World War I; formerly district physician of the city board of health; on the staffs of Mercy, Grant, and St. Ann's hospitals; died Jan. 29, aged 77, of coronary heart disease.

Carroll, Joseph Henry ✦ Burlington, Wis.; Milwaukee Medical College, 1911; health officer; served during World War I; at one time practiced in Milwaukee, where he was team physician for the Milwaukee Brewers baseball team, and on the staff of St. Mary's Hospital; on the staff of the Memorial Hospital, where he died Feb. 25, aged 70, of a heart attack.

Corkery, John Ripley ✦ Spokane, Wash.; Rush Medical College, Chicago, 1905; formerly a member of the surgical staff of the Mayo Foundation in Rochester, Minn.; died in the Sacred Heart Hospital Feb. 13, aged 73, of coronary sclerosis.

Cottrell, Judson G. ✦ Perth Amboy, N. J.; Hahnemann Medical College and Hospital of Philadelphia, 1906; served during World War I; on the staff of the Perth Amboy General Hospital, where he died Feb. 11, aged 72, of heart disease.

Craig, Ford B. ✦ Pitcairn, Pa.; Jefferson Medical College of Philadelphia, 1906; member of the board of health in Pitcairn; for many years medical examiner for Pennsylvania Railroad; died Feb. 9, aged 75, of coronary occlusion.

Devlin, Albert Joseph, Coral Gables, Fla.; University of Pennsylvania Department of Medicine, Philadelphia, 1904; for many years practiced in Philadelphia, where he was on the staffs of St. Christopher and St. Mary's hospitals; died Jan. 17, aged 75, of cirrhosis of the liver.

Drapiewski, Albin Joseph, West Nanticoke, Pa.; Temple University School of Medicine, Philadelphia, 1928; interned at the Mercy Hospital in Wilkes-Barre; died Feb. 11, aged 56, of postural hypertension.

Edwards, Charles Mundy ✦ Richmond, Va.; University College of Medicine, Richmond, 1896; served during World War I; for many years managing editor of the *Virginia Medical Monthly;* died Feb. 3, aged 80, of arteriosclerosis.

Edwards, Martin Russ ✦ Boston; Harvard Medical School, Boston, 1908; died Feb. 24, aged 75, of Hodgkin's disease.

Eha, Charles Edward ✦ Cincinnati; Pulte Medical College, Homeopathic, Cincinnati, 1909; fellow of the American College of Surgeons; for many years associated with the Bethesda Hospital, where he was secretary of the staff and at one time chief of staff, and where he died Feb. 8, aged 69, of cerebral hemorrhage.

Ellis, James J. ✦ West Frankfort, Ill.; St. Louis College of Physicians and Surgeons, 1909; died in the Barnes Hospital, St. Louis, Jan. 24, aged 73, of pneumonia, following an operation.

Ellis, John Dayduff ✦ Denver; Rush Medical College, Chicago, 1911; member of the Illinois State Medical Society and the American Association for the Surgery of Trauma; member of the founders group of the American Board of Surgery; fellow of the American College of Surgeons; formerly practiced in Chicago, where he was on the staff of St. Luke's Hospital and consultant at Illinois Masonic and Alexian Brothers hospitals; died March 9, aged 69, of cerebral hemorrhage and cerebral arteriosclerosis.

Elworthy, Robert William ✦ Elmhurst, Ill.; Northwestern University Medical School, Chicago, 1926; member of the American Academy of General Practice; died in the Passavant Memorial Hospital in Chicago March 15, aged 55, of coronary thrombosis.

Erikson, Ralph Wennerberg ✦ Chicago; Rush Medical College, Chicago, 1925; on the staff of the Swedish Covenant Hospital, where he died Feb. 13, aged 56, of massive intestinal hemorrhage due to bleeding duodenal ulcer.

Facey, Frederick Duncan ✦ San Fernando, Calif.; McGill University Faculty of Medicine, Montreal, Canada, 1920; fellow of the American College of Surgeons; on the staff of St. Joseph Hospital, Burbank, where he died Feb. 11, aged 63, of brain tumor.

Garner, John Elmo, Sr. ✦ Thomaston, Ga.; Baltimore Medical College, 1903; died in the Upson County Hospital Jan. 23, aged 75, of pulmonary emboli and coronary insufficiency.

Gedo, Mathias Stephen ✦ Forest, Ohio; Deutsche Universität Medizinische Fakultät, Prague, Czechoslovakia, 1923; member of the American Academy of General Practice; member of the Medical Society of the State of New York; at one time practiced in New York City, where he was on the staff of the Sydenham Hospital; died Feb. 7, aged 57, of cerebral embolus and coronary thrombosis.

Goad, Norman, Strange Creek, W. Va.; Chicago College of Medicine and Surgery, 1909; died in the Gassaway (W. Va.) Hospital March 8, aged 69, of multiple sclerosis.

Hartmann, Hermann Henry, Galion, Ohio; Columbus Medical College, 1890; served many years as mayor and as city health officer; past-president of the Crawford County Medical Society; died Feb. 13, aged 85, of injuries received in a fall on the ice.

Hedges, Albert Parker ✦ Evanston, Ill.; Chicago Homeopathic Medical College, 1890; formerly on the staffs of the Illinois Masonic, Lake View, and Ravenswood hospitals in Chicago; died in the Presbyterian Home Feb. 14, aged 92, of chronic myocarditis and generalized arteriosclerosis.

Hill, John Ewart ✦ Marshall, Texas; University of Texas School of Medicine, Galveston, 1918; died Jan. 11, aged 64, of coronary thrombosis.

Jenkins, David John, Scranton, Pa.; Albany (N. Y.) Medical College, 1898; from 1919 to 1931 Lackawanna County coroner; served during World War I; formerly chief of the rating board of the regional Veterans Administration office in Wilkes-Barre; died in Lansdale Nov. 10, aged 84.

Jensen, Ernest Harry ✦ Dearborn, Mich.; Jefferson Medical College of Philadelphia, 1950; interned at the Wayne County General Hospital and Infirmary in Eloise, Mich.; on the staff of the Detroit Receiving Hospital; consulting psychiatrist at Dearborn Medical Centre Hospital and Oakwood Hospital in Dearborn; died Jan. 9, aged 32.

Jones, Henry Aaron ✦ Slocum, R. I.; Medical School of Maine, Portland, 1896; at one time superintendent of the State Infirmary in Howard; past-president of the Cranston Chamber of Commerce and the Rotary Club; for many years assistant director of public welfare for the state of Rhode Island; died Jan. 15, aged 85, of coronary thrombosis.

King-McGill, Cecelia Antonia, St. Joseph, Mo.; Marquette University School of Medicine, Milwaukee, 1928; died in the Missouri Methodist Hospital Oct. 21, aged 57, of cerebral hemorrhage and hypertension.

McKee, William Edwin, Indianapolis; Hospital College of Medicine, Louisville, Ky., 1897; died Oct. 25, aged 85, of generalized arteriosclerosis.

McNeil, Gordon Charles ✦ River Forest, Ill.; Northwestern University Medical School, Chicago, 1943; interned at the Cook County Hospital in Chicago, where he was at one time a resident physician; a captain in the Army of the United States from 1945 to 1947; specialist certified by the American Board of Surgery; on the staff of the Walther Memorial Hospital in Chicago; died Feb. 3, aged 38.

Mega, Gaetano Thomas ✦ Brooklyn, N. Y.; New York Homeopathic Medical College and Flower Hospital in New York City, 1926; served during World War I; on the staffs of the Kings County Hospital and the Kingsway Hospital, where he died Jan. 29, aged 56, of a heart attack.

Pruett, Harry Jeroam ✦ San Francisco; Stanford University School of Medicine, San Francisco, 1917; served during World War I; died Feb. 23, aged 65, of auricular fibrillation.

Rose, Fred ✦ Millstadt, Ill.; St. Louis College of Physicians and Surgeons, 1892; died in Springfield March 1, aged 85, of coronary thrombosis.

Senkler, George Easton ✦ St. Paul; University of Pennsylvania Department of Medicine, Philadelphia, 1893; for many years associated with St. Luke's and Charles T. Miller hospitals; died Feb. 4, aged 86, of pneumonia.

Sherman, Henry Deer, New York City; Fordham University School of Medicine, New York City, 1919; died in the Montefiore Hospital Dec. 5, aged 63, of lymphosarcoma.

Shipp, Loring M. ✦ Henderson, Texas; University of Texas School of Medicine, Galveston, 1925; fellow of the American College of Surgeons; interned at the Jefferson Davis Hospital in Houston, where he was a resident physician; on the staff of the Henderson Memorial Hospital; died in Shreveport, La., Jan. 17, aged 56, of heart disease.

Simmons, Sterling Price ✦ Marshall, Mo.; St. Louis University School of Medicine, 1915; interned at the Kansas City (Mo.) General Hospital; member of the city planning board; past-president of the Saline County Medical Society; chief of the staff of the John Fitzgibbon Memorial Hospital, where he died Jan. 9, aged 69, of cerebral hemorrhage and arterial hypertension.

Smith, Charles Gordon ✦ Medical Director, Captain, U. S. Navy, retired, Menlo Park, Calif.; University of Virginia Department of Medicine, Charlottesville, 1899; entered the U. S. Navy April 19, 1901; retired Nov. 1, 1937; fellow of the American College of Surgeons; died in Oakland Nov. 24, aged 76, of encephalomalacia.

Stacy, George Herbert ✦ Peoria, Ill.; Northwestern University Medical School, Chicago, 1908; on the staffs of the Proctor Hospital, Methodist Hospital, and St. Francis Hospital, where he died Jan. 22, aged 76, of ruptured peptic ulcer.

Stegall, Robert Edward ✦ Moultrie, Ga.; Emory University (Ga.) School of Medicine, 1935; interned at the Grady Hospital in Atlanta, where he served a residency; past-president of the Colquitt County Medical Society; served during World War II; died Jan. 14, aged 44.

Steinlein, Oscar W., Brooklyn, N. Y.; University of Buffalo School of Medicine, 1901; member of the Medical Society of the State of New York; died Jan. 9, aged 86, of coronary occlusion.

Storms, Harold Ackerman ✦ Dobbs Ferry, N. Y.; New York Homeopathic Medical College and Flower Hospital, New York City, 1915; interned at the Cumberland Street Hospital in Brooklyn; served overseas during World War I; physician for the Dobbs Ferry Public School; on the staff of the Dobbs Ferry (N. Y.) Hospital, where he died Feb. 4, aged 66, of acute hemorrhagic pancreatitis.

Tidmore, Thomas Lee ✦ Atlanta, Ga.; Emory University (Ga.) School of Medicine, 1924; specialist certified by the American Board of Anesthesiology; member of the American Society of Anesthesiologists; head of the department of anesthesia at the Piedmont Hospital; died Feb. 5, aged 55, of coronary artery disease.

Treharne, Frank Edwin, Independence, Mo.; Rush Medical College, Chicago, 1935; member of the Missouri State Medical Association; served during World War II; died Feb. 22, aged 47, of uremia.

Williams, Mary Edith ✦ Chicago; University of Illinois College of Medicine, Chicago, 1917; fellow of the American College of Surgeons; on the staff of the Women and Children's Hospital, where she died Jan. 17, aged 70, of pulmonary edema and chronic rheumatic heart disease.

Winning, Charles Crain ✦ East St. Louis, Ill.; American Medical College, St. Louis, 1911; examiner of draftees during World Wars I and II and received citations from Presidents Roosevelt and Truman; associated with St. Mary's Hospital and the Christian Welfare Hospital; for many years local physician and surgeon for the Illinois Central Railroad; died Jan. 26, aged 69, of heart disease.

FOREIGN LETTERS

FRANCE

Essential Hypoproteinemia in Children.—M. Bernheim and his co-workers (*Pédiatrie* **10**:507, 1955) stated that essential hypoproteinemia and isolated agammaglobulinemia can be differentiated. The first is characterized by more or less generalized edema and deficiency in all the proteins. They treated an 8-year-old boy with this condition whose disease was acute and curable. Paper chromatography did not show hyperaminoaciduria. Isolated agammaglobulinemia is marked by a series of infections, usually of the skin or respiratory tract. These can be cured by antibiotics, but prevention can be accomplished only by repeated injections of gamma globulin. The authors treated a 15-month-old infant who had had seven bouts of micrococcic infection, twice accompanied by septicemia, within one year. The most recent episode had yielded only to spiramycin. The gamma globulin value in this infant was only 2.2%, whereas it should have been 15% at his age. Gamma globulin deficiency should be suspected in every infant who has many infections.

Idiopathic Proteinemia with Hyperaminoaciduria in Children.—In contrast to the previous report, A. Fontan and C. Martin (*Pédiatrie* **10**:515, 1955) describe a patient with deficiency of all the plasma proteins in whom there was quantitatively and qualitatively abnormal hyperaminoaciduria. The patient was an 8½-year-old girl whom the authors had treated over a four-year period for a chronic state marked by acute episodes of edema, diarrhea, and tetany. During the periods of remission there was discrete infiltration of the teguments.

Artificial Kidney.—Hamburger and Richet (*Rev. franç. étud. clin. et biol.* **1**:39, 1956) said that they performed dialysis with an artificial kidney on 60 occasions in anuric patients. Serum sodium, potassium, calcium, chloride, bicarbonate, sulfate, and phosphate levels were estimated in all patients before and after dialysis. Acute uremia is associated with both nitrogen retention and profound electrolyte disturbances. Some of the latter are remarkably constant and severe; a fall in the levels of calcium and chloride and an increase in those of magnesium and more especially sulfate are invariably found in this condition. Other electrolyte disturbances are, by contrast, inconstant and differ from patient to patient. Alterations in levels of sodium and potassium occur irregularly, the phosphate level may be increased greatly or not at all, and, although the bicarbonate level is usually very low, it may exceed normal values. All these disturbances are corrected by dialysis with the artificial kidney, which is, in this respect, much more efficient than other forms of dialysis (particularly in raising calcium levels and correcting anion abnormalities). The clinical findings in acute uremia are improved by the use of the artificial kidney. The most striking changes are improvement in the general well-being of the patient; the cessation of nausea, vomiting, and tympanites; the return of full consciousness; the abolition of convulsive seizures; and the correction of cardiovascular disturbances.

Both the clinical results and the biochemical findings confirm the fundamental role played by the electrolyte disturbances in acute uremia. Phosphate and sulfate retention and the alterations in anion equilibrium may be of greater importance clinically than has hitherto been recognized. Magnesium retention appears to be responsible for clouding of consciousness and for prolongation of the Q-T interval in the electrocardiogram. The convulsions and abdominal disorders are certainly related to some sort of biochemical disturbances, as dialysis with the artificial kidney abolishes them. The effect of dialysis is so clear-cut that it allows the differentiation to be made between acute abdominal distress due solely to biochemical disturbance and that due to a visceral lesion that may require surgical intervention. The present study does not, however, make it possible to correlate these clinical phenomena with any particular electrolyte disturbance.

Schoenlein-Henoch's Purpura.—L. Israel and his co-workers (*Rev. franç. étud. clin. et biol.* **1**:58, 1956) reported that serum from rabbits sensitized to guinea pig endothelium injected subcutaneously into guinea pigs, in doses of 3 ml., produced a nonthrombocytopenic purpura, analogous to Schoenlein-Henoch's purpura in man, with purpuric manifestations in the skin and digestive tract and hematuria, seen microscopically. An early phase was observed immediately after the injection of the serum and a second after the ninth day. As a test for capillary toxicity, 0.2 or 0.3 ml. of immunized rabbit serum was injected intradermally into guinea pigs. A local ecchymosis always resulted, with the histological characteristics of interstitial hemorrhage associated with pericapillary infiltration. The injection of normal rabbit serum did not cause ecchymoses. This test has made it possible to demonstrate the presence in guinea pigs with experimental purpura of the secondary and transitory phenomenon (from the third to the ninth day) of capillary toxicity of their serum. The intradermal test has also been found positive in all patients with acute articular rheumatism and in almost half those with either glomerulonephritis or cavitary pulmonary tuberculosis. Capillary toxicity of the serum is not specific to Schoenlein-Henoch's purpura but may also occur in other conditions affecting the capillaries.

SWITZERLAND

Birth Control.—Dr. L. Duc (*Praxis* **45**:138, 1956) questioned 440 couples with marital difficulties who applied to a marriage counseling service. Three-fourths of the women had been married before the age of 30, but only 60% came into the purview of this study before the age of 40. One-third of the couples had no children, which intensified the marital conflict and influenced the desire for divorce. The presence of children, especially if there were several, retarded the acute crisis by several years. (Most of the childless women were between the ages of 25 and 29, while those with children were between 30 and 34.) Sterility, an excessive number of children, illegitimate children, or children resulting from previous marriages were not specific causes of the conflict; they were only incidental factors. The practice of birth control did not threaten a marriage but was often a problem, inasmuch as 25% of these women feared pregnancy. The practice of birth control was influenced less by moral than by strictly material considerations and acquired experience. For example, it was more strictly practiced by couples in which one partner had been married before (25% of the cases) or had an illegitimate child (13% of the cases). Most women who practiced contraception already had children; the more children there were, the better the methods used. The practice led in general to better birth control and not to inopportune childlessness.

Women who had previously had illegitimate children were rarely forced to marry later, even though they had sexual premarital relations with their future husbands, because they practiced efficient contraception. They had but slight fear of pregnancy. The fear of pregnancy was usually not a neurotic manifestation but was real and material. It hardly existed at all in women who were involuntarily childless. The fear became increasingly strong with the number of children borne or existed already in remarried women who were supporting children from previous marriages. The fear was a little more frequent in those who practiced coitus interruptus, but it often persisted when safer contraceptive measures were used if these were not practiced until after a conditioned reflex of fear was established. Fear of pregnancy was a determining factor in the neurotic phenomenon of secondary frigidity. A dissociation of these two elements was observed in women with illegitimate children; they were often frigid but seldom fearful. Primary frigidity was more common

The items in these letters are contributed by regular correspondents in the various foreign countries.

in women who married before the age of 24, were strongly inhibited, feared pregnancy, and were careful to avoid conception before marriage, abstaining from premarital sexual relations from their fear and not because of moral feeling.

The fear of pregnancy and the frigidity caused by it should be treated prophylactically, because these constitute serious disturbances to mental health. This, however, is only a minor aspect of the problem. Socially, the most important problem is that of severe marital conflicts, especially those appearing early and dissociating the family when the children are most apt to suffer. These conflicts unfortunately tended to appear after two or more children had been born. The key factor in these early disharmonies was forced marriage, especially in women married before the age of 20. Early marriage, especially between the ages of 20 and 24, was a less unfavorable sign but also constituted a potential cause of trouble, at least in cities. More than 50% of the couples with children had conceived them before marriage, and about half had undergone true forced marriages. Half of the wives who had not conceived before marriage remained childless. Premarital conception was frequently the source of fear of pregnancy associated with frigidity. When one takes into account abortion and illegitimacy, two other serious consequences of ignorance among young persons, the repercussions of which are as bad as those of forced marriage, it appears that prophylactic measures in unmarried persons are more important than a better contraceptive orientation among married persons.

It is illusory to state that sexual abstinence before marriage is the prophylactic method of choice, because no amount of moralizing will change the behavior of most of the subjects. The inescapable conclusion is that proper education of the child for sexual and conjugal life is indispensable. This difficult task cannot be accomplished by the parents alone. It must be undertaken at school, but with the full cooperation of the parents. Objective teaching concerning birth control must be part of this program, especially for girls, since often the responsibility for contraception will fall on them in later life. If this orientation is given after careful ethical and psychohygienic preparation, there is no danger that it will predispose to debauch. Such a program must respect the personal, moral, and religious convictions of the population.

Penicillin V.—A group of Austrian authors have developed a method of obtaining various penicillins that differ in respect to their lateral chains. This consists in the use of "precursors," or enrichment of the culture medium with carbonic acids. One of the antibiotics thus obtained was phenoxymethyl penicillin, which is biosynthesized, with phenoxyacetic acid acting as a precursor. Unlike penicillin G, this agent, called penicillin V, occurs in the form of a free acid because of its great stability. The chief importance of this new penicillin is that it is acid-resistant. Serum determinations after the ingestion of 200,000 units of penicillin V show that its concentration is superior to that obtainable with penicillin G and that it remains effective for four or five hours. Thus the drug no longer has to be quintupled in amount when resistance is encountered, and the cost of oral therapy is greatly reduced. Penicillin V also has very good diffusion, rendering it useful in the presence of such conditions as pleurisy, cholecystitis, and ascites. Satisfactory clinical results have now been reported from several countries. Micrococcic and streptococcic septicemia and endocarditis have been treated with administration of 100 million units every four hours. Bickel and co-workers (*Schweizerische medizinische Wochenschrift*, vol. 86, 1956) made tests to determine whether it was necessary to administer the drug after fasting in order to avoid hyperacidity, as the Austrian writers had averred. This is not the case; in fact, it appears that it is best absorbed when given 30 minutes after a meal. Oral administration must be repeated every four hours, however, in order to assure a more or less constant blood level. Side-reactions to the drug seem to be about the same as those to other forms of penicillin (such as urticaria and glossitis). That no deaths due to anaphylaxis with its use have been reported does not mean this is not a possibility. Modifications of the intestinal flora must be expected. The gram-positive bacteria are apt to disappear, leaving a preponderance of resistant coliform organisms. The Swiss authors' first administrations produced diarrhea, with decimation of the flora in general and not of any particular group. However, De Sommer has shown that oral or peritoneal administration of penicillin in guinea pigs produces severe toxic changes that may be fatal. They are the result of destruction of all the gram-positive organisms and appearance of pathogenic coliform bacilli. Rohmer and Marie of France reported on digestive syndromes due to pathogenic colibacilli in clinics and infant homes. They did not blame antibiotics, but it may be that the pathogenicity of colibacilli, like that of the Micrococcus pyogenes var. aureus, is being modified under the influence of antibiotics. With proper caution, penicillin V can be administered orally, freeing the patient from the onus of frequent injections and certain sensitivity reactions.

Carbon Monoxide Poisoning.—It often happens in winter that some persons suffer from drowsiness and malaise from no apparent cause. Lob and Muller (*Revue médicale de la Suisse Romande*, January, 1956) state that carbon monoxide can exert a deleterious effect in daily life without the patient or physician being aware of it. According to Almgren, vertigo occurs in 69% of cases of carbon monoxide poisoning, insomnia in 66%, affective changes in 62%, cardiac symptoms in 62%, apathy in 54%, headache in 47%, nausea and vomiting in 42%, wasting in 42%, memory disturbances in 40%, frequency of micturition in 39%, tiredness in 32%, intolerance to alcohol in 28%, decrease in libido in 22%, anorexia in 17%, gastric symptoms in 17%, ocular disturbances in 13%, and sweating in 12%. The Romberg sign may be present in these patients, and there may also be ataxia, adiadochokinesia, a sensitivity hemisyndrome, labyrinthine disturbances, disorders of convergence and accomodation, oculomotor paralysis, narrowing of the visual field for color, and psychosomatic complaints. The electrocardiogram may show atrioventricular block and disorders of rhythm and conduction. Signs of hyperthyroidism may be present. Usually more than one member of the family is affected; the symptoms disappear when the heating system is turned off. The carbon monoxide content of the atmosphere can be measured with apparatus having a hopcalite catalyst.

UNITED KINGDOM

Doctors on the Air.—The central ethical committee of the British Medical Association has again examined the question of the anonymity of physicians on radio and television and recommends that physicians appearing on the air should insist on remaining anonymous as part of their contract with the British Broadcasting Corporation. This stand is further endorsed by the General Medical Council, which is a disciplinary body. The report referred to the increasing observance of anonymity by most physicians when on the radio and its nonobservance by some important leaders of the profession, whose names, qualifications, and status were announced as part of a build-up before they actually appeared. Disturbing factors were the occasional appearance of patients on television to demonstrate some new or successful form of treatment and the subsequent volume of letters from the public to the physician concerned. This often upset the doctor-patient relationship and sometimes resulted in criticism of the physician who was on the air by the general practitioner in charge of the patient. Success over the air need not depend on disclosing the speaker's name. Many anonymous physicians have been a success on radio. Any relaxation of the present ruling is likely to bring discredit on the profession, detract from its dignity, and promote a form of public practice that would tempt unethical practitioners to exploit the situation to their personal advantage. Ethical standards would be lowered and self-diagnosis and self-medication promoted.

The report was discussed in council. One member said that the rule should not apply when a physician was speaking on behalf of and at the request of the profession. A distinction should be made between those who were on the air for their own advantage and those doing it in the public interest. Other speakers said that no distinction could be made. If there is to be anonymity, it must be absolute. The public health committee of the British Medical Association still insists that health officers remain anonymous when giving talks to the public on the air. One of the dangers of revealing the physician's name on the air

is the possibility of undermining the confidence of the patient in his or her own physician. The eminent professor or specialist might present a medical view, perhaps not shared by the rest of the profession, opposed to that given by the general practitioner to his patient. The recommendation of the central ethical committee that anonymity over the air be preserved was accepted by the council.

Extraperiosteal Apicolysis with Plombage.—Jackson and McCann have reviewed their series of 203 patients with extraperiosteal apicolysis with plombage over a period of two to five years (*Tubercle* **37**:36, 1956). The materials inserted into the extrapleural space to preserve permanent collapse of the lung were polymethyl methacrylate (Perspex), used in the form of hollow spheres, and polyethylene sponge packs (Polystan). The plombage material absorbs the serosanguineous effusion with increase in weight and volume and with collapse and compression of the lung. As the fluid becomes absorbed and organizes, contraction of the plomb occurs allowing ascent of the diseased lung. The patients in this series would normally have undergone thoracoplasty for the control of their tuberculosis. In most of them the disease was active, with infiltrative lesions and cavitation. Because in 85.4% of those with unilateral lesions and 75% of those with bilateral lesions control of the disease was achieved without complications, plombage was once the preferred procedure. Owing to the introduction of effective antituberculosis drugs, this form of therapy now has a limited application. Plombage is restricted by these workers to patients with bilateral lesions in whom maximal conservation of respiratory function and early control of the disease is essential, to certain older patients on whom resection is considered unwise and thoracoplasty dangerous, and to certain patients when the plombage operation is a means to an end rather than the definitive treatment. The incidence of complications in these patients was minimal, but the problem of infection that occurred in 12 of them remains to be solved. As the trend of surgery at present is more toward the removal of the infected focus rather than toward its collapse, the indications for plombage are becoming fewer.

Energy Expended by Patients at Rest.—For many years the basis of therapy in the management of pulmonary tuberculosis has been rest. Some patients are kept in bed but are allowed to perform certain activities such as washing, bathing, and using the toilet. Others are allowed various forms of occupational therapy. Dr. G. M. Little has compared the work involved in these actions (*Tubercle* **37**:25, 1956). He measured the ventilatory cost as an index of work done by the patient and by the lungs. The subject under test breathed in outside air through a mouthpiece and two-way valve, and the expired air was led into a gas meter. Various actions were then performed, and the air exhaled every 30 seconds was measured. The volume of air the subject exhaled while taking a bath was 201 liters, walking 1,100 yd. 161 liters, bathing in bed 72 liters, using the bed pan 59 liters, using a commode 20 liters, and being wheeled to the lavatory by chair 54 liters. These findings suggest that the use of the bed pan presents no advantages as a means of conserving the patient's energy. Using a commode entails less ventilatory effort and, hence, less expenditure of energy than other methods of defecation. The ventilatory cost of various occupational therapy activities was also measured. A subject in doing sewing used 22 liters of air in unit time, painting 33, weaving 21 to 75 (according to kind of loom), basketwork 41, woodwork 123, sweeping up leaves 82, and hoeing 62. The total expenditure of energy on these activities depended on the time spent doing them. The quietest form of activity was art work.

New Thyromimetic Drug.—Trials with a new thyromimetic drug were described by Dr. Russell Fraser before the endocrinology section of the Royal Society of Medicine on Feb. 22. This is Triac, a derivative of triiodothyronine, in which the α-aminopropionic acid side-chain is replaced by aminoacetic acid (Glycine). Triiodothyronine is not active in vitro and is therefore not the hormone that circulates in the body. Altering its side-chain as indicated to form Triac renders it active in oral use. The latter is only about one-tenth as active as the parent substance, but it produces its effects far more quickly. According to Fraser, Triac acts more rapidly than any thyroxine-like compound yet studied clinically. It can alter the electrocardiogram of a myxedematous patient in a few hours and the basal metabolism rate within a few days. The dosage is 6 to 12 mg. daily. It is claimed that Triac can disperse myxedematous fluid without a rise in the basal metabolism rate. For routine use Triac presents no advantage over thyroid gland or thyroxine, but it is of special value when a rapidly acting thyromimetic drug is required, as in coma due to myxedema or in the treatment of those patients with myxedema in whom the risks of cardiac complications are uncertain. In the latter case, it can be given in small doses and rapidly withdrawn if there is any sign of overdosage.

Death from Hexobarbital.—A woman who suffered for several years from bronchitis had 18 teeth extracted. When examined by the anesthetist she was found to weigh only 80 lb. (36.3 kg.) and to have signs of bronchitis. She was given 0.9 gm. of hexobarbital intravenously. Her teeth were extracted and about 50 minutes later, as her condition appeared to be satisfactory, she was left in the care of her sister, who was instructed how to treat her. Two hours later the patient did not appear to be breathing, and a physician was called. He applied artificial respiration and injected epinephrine into her heart, but she died. At the inquest the pathologist stated that he could find no natural cause of death. There was evidence of severe and long-standing bronchitis and emphysema, which did not appear to be active. He concluded that the patient died from the effects of the anesthetic. In a patient with advanced bronchitis and emphysema, depression of the respiratory center with its resulting anoxemia and retention of carbon dioxide may cause death. In the pathologist's opinion, nitrous oxide would have been a safer anesthetic for such a patient. A verdict of death by misadventure was returned.

Control After Colostomy.—Having had a colostomy should be no handicap to any patient. Most patients accept their condition and approach the new mode of bowel evacuation as a matter of necessity. In a letter to the *British Medical Journal*, a patient who had had a colostomy described his own method of keeping constipated by using aspirin and the granular form of methyl cellulose (celevac). Drinking tea on waking in the morning usually produced an evacuation, but evening actions were found to be unpredictable. With this method "accidents" may be frequent. Another letter in the journal of Jan. 21 by S. O. Aylett advocates irrigation. He said the patients at the Gordon Hospital, London, are taught this method. The irrigation takes about 30 minutes each morning, after which the patient can, with confidence, continue his normal daily work and social activities. There was no need to wear a bag or bulky absorbent dressings. The method was safe, and in his own practice there had been no case of perforation of the bowel.

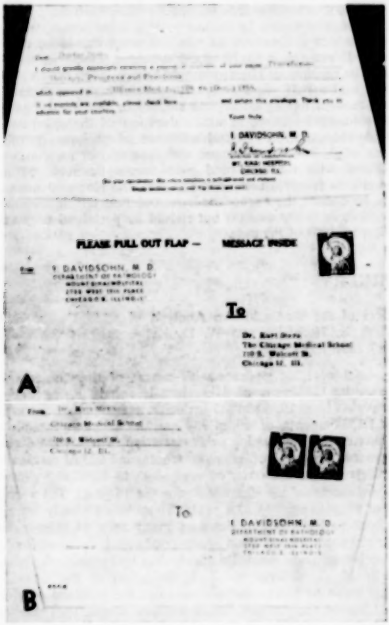
Compulsory Nursing.—At a meeting of the Wakefield (Yorkshire) Group Hospital Management Committee, the chairman, discussing the difficulties of recruiting nurses, said that the position was so grave that it should be dealt with at a national level. He thought that the time might come when a form of compulsory service might have to be considered by which young women would be directed into the nursing service, just as young men are drafted into the armed forces at 18 years of age. The position would be equivalent to that of a state-enrolled assistant nurse. Measure after measure had been tried to recruit nurses but nothing really effective had been discovered so far. The committee decided to ask the Ministry of Health to examine salary grades and conditions of service to see if these are sufficient to attract young women into the nursing profession.

"Espresso" Wrist.—A large number of espresso coffee bars have sprung up in the last year or two. Dr. Kessel, an orthopedist, has described a wrist complication in those who operate the coffee dispensers. For each cup of coffee poured out, three to four strong movements of the wrist into full radial deviation have to be carried out, and in the average day several thousand such maneuvers are often made. Bartenders are not so affected because beer is drawn with the wrist held stiffly, the elbow being flexed. This acute condition in the espresso coffee machine operators responds to one or two injections of hydrocortisone.

CORRESPONDENCE

RETURN REPLIES

To the Editor:—In THE JOURNAL, March 3, 1956, page 801, Dr. Alexander Sterling suggested that requests for reprints be accompanied by a self-addressed, stamped return envelope. In this connection, I wish to call attention to an envelope that I have used for requesting reprints for several years (see figure).



A, top of envelope, with flap pulled out. *B*, top of envelope ready for return mailing.

The envelope measures 8½ by 11½ in. The addressee is asked to pull out the flap containing the signed request. If reprints are not available, there is a place on the flap to state, without having to write a separate letter. The reprint is placed in the envelope; the flap, with the return stamp and address, is sealed; and the reprint is on its way.

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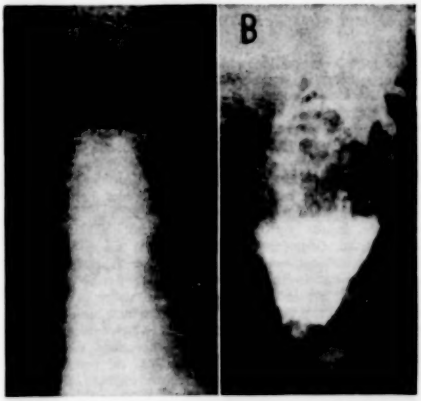
UNUSUAL CAUSE OF FLUID LEVEL IN THE UPPER MEDIASTINUM

To the Editor:—We wish to report an additional possibility to be included in the differential diagnosis of fluid level in the upper mediastinum. In our patient the fluid level was caused by a chronic, long-standing stenosis of the esophagus after ingestion of lye. Among the more common causes of mediastinal fluid levels one must consider, first, mediastinal abscess, or, less frequently, esophageal diverticulum, mediastinal cyst, diaphragmatic hernia, or cardiospasm. A 52-year-old woman was referred for a radiological examination because of fever of one week's duration and a slight cough. The standard posteroanterior roentgenogram of the chest showed in the upper mediastinum a large fluid level with no other significant pathological findings (see figure, *A*). A lateral roentgenogram localized the fluid level to the posterior upper mediastinum and showed the trachea to be displaced forward by this mass. The possibility of an esophageal cause was considered, and an esophageal examination was performed. A swallow of barium demonstrated clearly an obstruction in the middle third of the esophagus at the level of the bifurcation of the trachea, causing the fluid level in the esophagus (see figure, *B*). The barium had not passed the site of the obstruction after 30 minutes. A hypodermic injection of an antispasmodic (Fisostina) was given, and 15 minutes later the barium passed the obstruction and outlined the esophagus in the region of the stricture. The esophagus was narrowed throughout its entire lower half. The pathological picture was attributed to a benign stricture. When questioned further the patient remembered having swallowed lye 23 years earlier. Since that time she had been having intermittent mild dysphagia. An esophagoscopic examination was done later and confirmed the radiological diagnosis. The patient is currently undergoing dilatation with bougies,



Roentgenograms. *A*, showing fluid level in upper mediastinum. *B*, after swallow of barium, showing the fluid level caused by the esophageal obstruction.

and later, if the condition is not corrected, an operation will be performed. This case illustrates an atypical cause of a fluid level in the upper mediastinum. This condition should be considered in the differential diagnosis of such fluid levels.

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MEDICAL LITERATURE ABSTRACTS

INTERNAL MEDICINE

Results of Prednisone Therapy in Tuberculous Pleurisy with Effusion. V. Baroni and M. Scolari. Minerva med. **46**:1719-1723 (Dec. 12) 1955 (In Italian) [Turin, Italy].

Administration of prednisone in initial daily doses of 15 to 20 mg. for the first 4 days and 10 mg. for the following 10 to 15 days gave good immediate results in 12 tuberculous patients in most of whom pleurisy with effusion had developed during collapse therapy. The patients' response to the therapy was prompt, and in all of them the drug inhibited the exudative process without causing significant side-effects. One advantage of prednisone was the fact that during its administration it was not necessary to keep the patients on a special diet. Other advantages were the facts that it had no side-effects on the gastrointestinal chemical processes and that it could be given orally. The mechanism of action of prednisone in tuberculous patients in whom pleurisy with effusion is present is very much like that of cortisone and corticotropin. The action of prednisone is, however, more constant. It also gave good results in patients in whom cortisone had been of little avail. Like cortisone, prednisone does not always have a lasting effect. Effusion often reappeared in these patients one or two weeks after the therapy had been interrupted. In view of this fact, the authors suggest that maintenance doses of prednisone ranging from 5 to 10 mg. be given in daily divided doses for two to three weeks after the effusion has disappeared. Coexisting parenchymal foci were never aggravated and inactive processes never became reactivated in these patients during the prednisone therapy.

The Selection of Anti-Microbial Drugs for Patients of Different Categories. E. H. Rebitzek. Dis. Chest **29**:174-186 (Feb.) 1956 [Chicago].

The author's observations and those by other workers, collected from the literature, suggest that treatment of tuberculosis has been complicated rather than simplified by the introduction of newer, more potent antituberculous chemotherapeutic agents. Omitting the diaminodiphenylsulfone derivatives and the thiosemicarbazones, the truly potent, clinically applicable antituberculous drugs are isoniazid, streptomycin, and *p*-aminosalicylic acid (PAS) in various combinations. Potentially important are oxytetracycline (Terramycin) and pyrazinamide. Less effective against the Mycobacterium tuberculosis, but with special fields of usefulness, are the isopropyl derivative of isoniazid (Iproniazid) and viomycin. Of uncertain usefulness are salts of isoniazid and chemical combinations of streptomycin with isoniazid and aminosalicylic acid with isoniazid; the former offer no advantage, and the latter are still experimental. Still under investigation but giving great promise is cycloserine, a new antibiotic extracted from orchidaceous streptomyces. Choice of drug regimens depends on initial evaluation of the patient's condition, estimation of sensitivities, and knowledge of the history of the disease in the given patient. Drug regimens should always include isoniazid, to date the most potent antituberculous agent, unless allergy or toxicity rules otherwise. Minimal exudative lesions call for combined treatment with isoniazid, streptomycin, and aminosalicylic acid; the treatment would be streptomycin, 450 to 600 mg. of isoniazid, and 12 gm. of *p*-aminosalicylic acid daily for one month at least. Far-advanced, cavitary, and fibrotic disease requires a prolonged course of antimicrobial agents; therapy should be instituted with isoniazid and *p*-aminosalicylic acid and should be continued as long as possible, depending on sensitivity studies. With evidence of development of resistance, streptomycin should be added to the two other drugs. Upon development of resistance to isoniazid or streptomycin, oxytetracycline therapy should be instituted. If it is the streptomycin to which resistance develops, its administration should be discontinued; if resistance to isoniazid develops, isoniazid therapy should be continued. Therapy should be continued for from one to one and a half years except for special cases, such as that of the patient having undergone surgery or that of the patient with primary infection, in which duration of therapy may be considerably shorter. Pleural effusions of presumably tuberculous origin call for treatment with isoniazid or for combined treatment with isoniazid and *p*-aminosalicylic acid. Miliary tuberculosis requires combined therapy, and isoniazid must always be one of the agents used. Ambulation during treatment is feasible in many patients but should be permitted only after careful analysis of the case.

SURGERY

Cancer of the Stomach: An Analysis of 1,152 Cases. D. B. Shagon, S. Horowitz, and W. D. Kelly. Surgery **39**:204-221 (Feb.) 1956 [St. Louis].

A total of 1,201 patients with cancer of the stomach was seen at the University of Minnesota Hospitals during the 14-year period from 1936 to 1949 inclusive. This report is concerned with 1,152 patients, of whom 934 had the diagnosis established by microscopic verification or at operation. There were 6 cases of lymphosarcoma, 3 of leiomyosarcoma, and 925 of carcinoma. The delay from the onset of symptoms to surgical treatment was not shortened significantly during the 14 years. The average age of all patients was 62.8 years. There was a steady increase in older patients. Three times as many men as women had gastric cancer. Examination of aspirated gastric contents for free hydrochloric acid revealed achlorhydria or hypochlorhydria in 87.8% of all patients tested. Examination of the feces for occult blood by the guaiac test revealed the presence of blood in 83.2% of the patients. These are two simple tests that can be performed in the physician's office and are a great help in the early diagnosis of gastric cancer. The trend in operability and resectability from 1936 to 1949 demonstrates a 30% increase in operability during the 4-year period 1946 to 1949, as compared with a 4-year period 10 years earlier. More than twice as many lesions were considered resectable during the later period in comparison with the earlier period. The mortality rates of all gastric resections, including the total and partial resections performed during 1936 to 1939, was 38.8%; during 1940 to 1945, 12.1%; and during the years 1946 to 1949, 8.8%. The 5-year survival rate for all cases for the entire 14-year period was 9.5% (109 cases), and that of patients who underwent "curative resections," 24.7%. Forty-four per cent of patients in whom the lymph nodes had not become invaded survived five years or more after gastric resection, as compared with 11.4% of patients in whom the lymph nodes had become invaded. During 1946 to 1949, over 70% of patients resected for "cure" had lymph node involvement; 14.5% of these survived five years or more. During this same period, 57.1% of patients without invasion of the lymph nodes survived five years after gastric resection. The authors feel that knowledge gained through "second-look" operations should enable surgeons to further improve the five-year survival rate in the future.

The place of publication of the periodicals appears in brackets preceding each abstract.

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NEUROLOGY & PSYCHIATRY

Cerebral Hemispherectomy in Treatment of Hemiplegia and Certain Infantile Encephalopathies. D. Ferey. Presse méd. **64:**81-84 (Jan. 18) 1956 (In French) [Paris, France].

Hemispherectomies were performed on 10 patients with infantile encephalopathy or infantile cerebral hemiplegia who ranged in age from 4 to 20 years. Seven had epilepsy and eight severe behavior disorders making institutionalization imperative and learning impossible. All were retarded mentally, two to the point of idiocy. The patients were subjected to thorough examination before operation was decided on. The author states that the candidate for hemispherectomy must have one healthy hemisphere. Operation is refused to those in whom the hemisphere that would remain shows small atrophic lesions recognizable on pneumoencephalograms or ventriculograms. The basic idea of the intervention is to remove all of the diseased hemisphere except for the caudate nucleus, thalamus, lenticular nucleus, and their vascular supply. A previous arteriogram will inform the surgeon as to the degree of displacement of the superior longitudinal sinus, so that it can be avoided. Two patients of the present series died unexpectedly the day after operation. The survivors were greatly benefited by hemispherectomy. Five of six patients with epilepsy have been free of attacks, and the sixth had had only one attack and was in good health on Gardenal therapy at the time of writing. Since no patient has been observed for more than 26 months, these results cannot be said to be definitive. Behavior was consistently improved, so that all the patients but the two idiots could live at home. In patients with unilateral encephalopathy, this indication alone is sufficient for hemispherectomy. The same is true for mental deficiency, since the benefit obtained among this group allowed the children to begin reading and writing and generally to return to a near-normal life for their mental age. Results were less brilliant in hemiplegia. There was a beneficial action on contracture, but nothing could be done for atrophy or shortened limbs. The hand usually remained useless. Pre-existing hemianopsia persisted. Two girls who had never spoken began to say a few isolated words. The intervention also caused the appearance of appetite, with consequent weight gain.

Craniovascular Studies in Headache: A Report and Analysis of Pulse Volume Tracings. P. Brazil and A. P. Friedman. Neurology **6:**96-102 (Feb.) 1956 [Minneapolis].

In 188 patients with migraine and in 103 with tension (muscle contraction) headache, direct measurements of pulsation in the temporal, occipital, and supraorbital arteries were obtained by electrical recordings made from the volume changes in these arteries while one of three preparations was injected parenterally. The three preparations used were the methanesulfonate of hydrogenated ergotamine (dihydroergotamine), nicotinic acid, and sterile water. Normally, dihydroergotamine induces vasoconstriction of the extracranial arteries, while nicotinic acid produces a vasodilating effect. Objective and subjective responses to the injections were observed and recorded. In addition, certain aspects of the blood flow in the areas of the face supplied by the external maxillary artery were recorded qualitatively with the use of photoelectrometric principles. Results supported the supposed mechanism of extracranial arterial volume changes occurring during a migraine attack, since the authors found subjective or objective responses to dihydroergotamine, which diminished the volume pulse amplitude and eased the headache in 69 (91%) of the 76 patients with migraine to whom this drug was given. Thirty-three (78%) of 42 patients with muscle contraction headache to whom nicotinic acid was given obtained complete or partial relief of their headache and showed pulse-wave changes of increased amplitude; a sufficiently significant number of these patients thus evidenced a response to nicotinic acid that justified postulation of the belief that local vascular insufficiency plays a definite part in the mechanism of pain. It may well be that such an insufficiency occurs secondarily to local muscle contraction. The effects of the various drugs were felt by the patients before associated changes could be recorded objectively. Occasionally, pulse wave patterns obtained from the patients resembled mirror reflections of the standard patterns. In other patients there was complete dissimilarity of the pulse-wave contours, not only from each other on different sides of the head but also from the standard pattern. The significance of these findings in the authors' recordings has not yet been clarified.

GYNECOLOGY & OBSTETRICS

The Hormonal Cause of the So-Called Varicose Veins in Pregnancy. P. H. Fried, P. K. Perilstein and F. B. Wagner Jr. A. M. A. Arch. Surg. **72:**253-261 (Feb.) 1956 [Chicago].

The superficial venous disorders of the lower extremities during pregnancy have been identified as the classical superficial saphenous varicosities. The authors recently differentiated from the saphenous varix a completely different, superficial venous disorder that is limited to the pregnant state. They applied to it the term "angiectid." The angiectid does not resemble the long, cord-like, subcutaneous saphenous varicosity, but is a small, superficial, intradermal, raised sharply circumscribed clump of bluish vessels that has a predilection for specific sites. It is often warm and tender. With the exception of the angiectids, the venous systems of these patients are generally normal. The pain caused by the angiectid is in contrast to the heaviness and fatigue of the legs occasioned by the saphenous varix. Often it is severe enough to prevent the patient from standing for more than five minutes. Many clinical features of the angiectid imply a relationship between the disorder and changes in the normal balance of estrogen and progesterone. In all instances the women were young and the angiectids appeared during the first trimester of one of their first three pregnancies. About half of the patients found that the angiectids disappeared completely by the sixth postpartum week. The remainder had faint intradermal vestiges that in some instances were associated with premenstrual changes and mild pain. Hormone assays in 21 patients with angiectids demonstrated normal amounts of serum chorionic gonadotropin and urinary 17-ketosteroids and variations in the titers of serum estrogen and urinary pregnanediol. The six women with symptomless angiectids had consistently low-normal amounts of estrogen and pregnanediol. Of the 15 patients with painful, disabling angiectids, 14 had subnormal amounts of estrogen and/or pregnanediol. Severe pain and marked changes in the angiectid were associated with the lowest estrogen levels. In contrast to these findings, the results of the hormone assays in four patients with saphenous varices were normal. Pain and disability due to the angiectids disappeared in each of the 15 patients with the oral administration of female sex hormones. Diethylstilbestrol alone was effective in 13 patients.

Isoniazid and Pregnancy. P. Aboulker and S. Muhlrad. Presse méd. **64:**45 (Jan. 11) 1956 (In French) [Paris, France].

Three pregnant women with renal tuberculosis were given isoniazid alone or in combination with aminosalicylic acid without interruption during and after their pregnancies. Their respective total doses during pregnancy were 63, 35, and 32 gm. of the drug after two, four and a half, and five and a half months of pregnancy. The treatment was successful in all the patients and was sufficient to cure one of them without the aid of nephrectomy. The course of pregnancy was not affected in any way, and the children born were normal at birth and at follow-up 8½, 14, and 14 months after birth respectively.

Question of Hormonal Production of Fetal Hermaphrodism in Human Beings. F. Hoffmann, C. Overzier and G. Uhde. Geburtsh. u. Frauenh. **15:**1061-1070 (Dec.) 1955 (In German) [Stuttgart, Germany].

The authors present the case of an infant who at birth showed, in place of the clitoris, a phallus with swollen prepuce surrounded by scrotum-like swollen labia majora. The genital swelling subsided within 10 days. Examination at the age of 11 months showed normal female genitalia except for the greatly enlarged clitoris. The mother of this infant had been troubled with itching of the skin during her pregnancy. Without the knowledge of the obstetrician, a dermatologist had tried to counteract the itching by the administration of male hormones.

Beginning with the fourth month of pregnancy, weekly and later biweekly injections of a testosterone preparation had been given, and during the last month of gestation a testosterone preparation had been administered by mouth. The woman's voice had become considerably deeper during this period of treatment with male hormones, and this voice change still persists. The use of hormones, particularly of male sex hormones, should be avoided during pregnancy.

PEDIATRICS

The Possibility of Total Elimination of Retrolental Fibroplasia by Oxygen Restriction. L. P. Guy, J. T. Lanman and J. Dancis. Pediatrics **17**:247-249 (Feb.) 1956 [Springfield, Ill.].

The authors describe studies on the effect of oxygen therapy on the eyes of prematurely born infants in the Bellevue Hospital premature infant nursery. One hundred forty-eight surviving infants below 2,000 gm. (4.5 lb.) in weight received restricted oxygen therapy under these regimens between August, 1952, and January, 1955. Cicatricial retrolental fibroplasia developed in none of them, and the vascular stage lesions that developed in 7 of the infants regressed to normal. The authors believe that retrolental fibroplasia can be either completely or almost completely eliminated by administering oxygen only at times of clinical need, and then for as brief periods as possible and at concentrations of less than 40%. Mortality rose slightly during the period of oxygen limitation; the rise was not statistically significant. The possibility of a relationship to oxygen limitation is discussed, but the authors believe that such a relationship is not likely.

The Treatment of Hyperthyroidism in Childhood with Thiouracil Drugs. J. J. Van Wyk, M. M. Grumbach, T. H. Shepard II and L. Wilkins. Pediatrics **17**:221-229 (Feb.) 1956 [Springfield, Ill.].

Since the introduction of thiouracil 12 years ago, the incidence of prolonged remissions after discontinuation of treatment with the antithyroid drugs has ranged between 45 and 75% in most series of adult patients. Only about 1% of cases of hyperthyroidism involve children, and so there has been little opportunity to evaluate therapy with the antithyroid drugs in children. Information is needed especially to assess the effect of puberty and adolescence on children in whom remissions have been obtained. During the past 10 years thiouracil and propylthiouracil have been used to treat all children with hyperthyroidism in the Harriet Lane Home Endocrine Clinic. Follow-ups are available on 16 children whose disease began before they were 13 years of age. Eight of this group are now in a period of prolonged remission; four have required subsequent surgery, and four are still under treatment. The advent of adolescence has not been found to induce a relapse in any child who was previously in remission. Reduction in the size of the goiter while the patient is receiving treatment has been found to be the best prognostic sign. The combined use of thyroid with antithyroid drugs caused involution of the gland in those patients whose goiters had remained large after treatment with propylthiouracil alone. The ultimate value of this combined treatment remains to be determined. It is recommended that surgery be reserved for those children who are sensitive to antithyroid drugs, who fail to cooperate, or who cannot be followed closely. In the remainder, treatment with antithyroid drugs should be continued until there is substantial reduction in the size of the gland. Two years of continuous therapy is suggested as the minimal period of treatment.

OTOLARYNGOLOGY

Prevention of Postoperative Adenotonsillectomy Bleeding with Vitamin K and Vitamin C. H. P. Harkins. Ann. Otol. Rhin. & Laryng. **64**:1137-1145 (Dec.) 1955 [St. Louis].

Since adequate amounts of vitamin K are essential to the normal production of prothrombin and subsequent firm clotting, and since vitamin C is necessary for firm and rapid healing, it was thought that adequate doses of each given before and after tonsillectomy and adenoidectomy might prevent both early and delayed postoperative bleeding. Two hundred children from the author's private practice were selected for the study. It was decided that both the tonsils and adenoids should be removed in each case. The ages of the patients ranged from 5 to 13 years. One-half of the group were given vitamin K and vitamin C before and after operation. The medication was prepared in soluble capsules containing 5 mg. of vitamin K and 200 mg. of vitamin C (Synkayvite-CB) each. The mother of each patient was instructed to give her child two capsules a day, one after breakfast and one after dinner, for the five days preceding the operation and again for the five days after operation. If a patient was unable to swallow the large capsule, the enclosed powder was placed on jam, jelly, mashed potato, or some other food that the child enjoyed. This could be followed by milk or water to assist swallowing. Fifty of the treated patients were allowed to use acetylsalicylic acid in gum or tablet form to relieve postoperative pain. The remaining 50 were denied the use of any salicylates to determine the influence of this drug on postoperative bleeding, which was reduced from 14% in the untreated series to 3% in the treated group. The frequency of postoperative bleeding was not increased when acetylsalicylic acid was used by those patients who had received adequate dosage of vitamin K and vitamin C. No toxic symptoms attributable to vitamin K or vitamin C were noted. In both the treated and the control groups, postoperative hemorrhage from the adenoid area was much more frequent than from the tonsil areas. Although careful bleeding-time and coagulation-time studies were made, these tests failed to indicate impending bleeding in the children who suffered postoperative hemorrhages.

THERAPEUTICS

Use of Certain Sulfonamides in the Treatment of Experimentally Induced Diabetes Mellitus: Personal Research (1942-1946). A. Loubatières. Presse méd. **63**:1701-1703 (Dec. 10) 1955 (In French) [Paris, France].

In 1942, Janbon and co-workers found that a lowering of blood sugar occurred in patients with typhoid fever who were given 2254 RP (*p*-aminobenzene-sulfamidoisopropyl-thiodiazol). Since then the author has shown that this substance acts directly on the islets of Langerhans and not on centers in the nervous system stimulating insulin secretion. The drug stimulates hepatic glyconeogenesis. It does not cause hepatic or renal lesions. It does not inhibit the diabetogenic effect of anterior pituitary extract and, in vitro, it does not activate the normal processes of blood glycolysis. In alloxan-induced diabetes of rabbits, 2254 RP will attenuate or cure the disease. On making this discovery in 1946, Loubatières proposed a therapeutic trial of the substance in man. His findings subsequent to 1946 are described in another paper.

Sulfonamides in Treatment of Diabetes Mellitus: Personal Research (1946-1955): Confirmation of Experimental Data and Recent Developments. A. Loubatières. Presse méd. **63**:1728-1730 (Dec. 14) 1955 (In French) [Paris, France].

In 1954 and 1955, Loubatières verified the findings of Von Holt and co-workers regarding the hypoglycemic and antidiabetic effects of 2254 RP (*p*-aminobenzene-sulfamidoisopropyl-thiodiazol) in normal and diabetic rabbits. The drug attacks the alpha cells of the pancreas, thereby inactivating the hormone glucagon. This destruction compensates for that caused by alloxan in the beta-cells. The author found that alloxan-induced diabetes in dogs was harder to treat than that in rabbits. Cures can be obtained in dogs when the disease is mild and of recent origin. A cured dog will relapse after total pancreatectomy, which fact demonstrates the exclusively intrapancreatic nature of the phenomena associated with 2254 RP. A rabbit can be rendered diabetic and cured again several times by alternate administration of alloxan and 2254 RP. Besides altering the alpha cells, 2254 RP appears capable of stimulating the beta (insulin-secreting) cells. Regeneration of these cells seems possible in some species by virtue of the lesions in the alpha cells. The drug has proved its value in the treatment of human diabetes mellitus,

BOOK REVIEWS

A Handbook of Hospital Psychiatry: A Practical Guide to Therapy. By Louis Linn, M.D., Assistant Attending Psychiatrist, Mount Sinai Hospital, New York City. Cloth. $10. Pp. 560. International Universities Press, Inc., 227 West 13th St., New York 11, 1955.

Dr. Linn set himself the task of providing a handbook for the psychiatrist working in a mental hospital. It is as simple as a primer and as comprehensive as Webster's Unabridged Dictionary. The author has succeeded admirably in providing what will surely become an indispensable manual for all workers in the field. Recognizing the difficulties the young psychiatrist has regarding theoretical concepts of psychiatric thinking, Linn has carefully presented the psychoanalytic theory of human behavior and thought as the framework of his approach to the mental hospital as a "therapeutic community." The author sees the physician working in a mental hospital as a kind of "general psychiatrist," called on to cope with the widest and most diverse range of situations.

Part 1, dealing with the treatment program, has chapters on individual, group, and somatotherapy. The chapters on the nonpsychiatric forms of therapy such as recreational, occupational, vocational, and food should be particularly helpful. The chapter on food is an example of how Linn has used every aspect of the therapeutic community to help the physician understand the patients' needs. Part 2 describes the treatment team, consisting of social worker, psychologist, attendant, nurse, chaplain, and volunteer worker. No special chapter is devoted to the psychiatrist, but he is mentioned in every chapter and on every page. This part of the book should prove to be especially useful to psychiatrists who have administrative duties. Part 3 helps us to understand the needs of patients. It deals with the chronic patient, the aged, children, adolescents, the alcoholic, the addict, the mental defective, the epileptic, the pregnant, the veteran, the sex deviate, the criminal, and the physically ill. Wherever necessary, in addition to the psychiatric aspects, social and legal questions are discussed. Part 4 has to do with the hospital and covers such problems as architecture and administration, statistics, staff education, research, forensic psychiatry, the hospital laboratory, and a psychiatric service in a general hospital. Part 5, on the community, discusses the difficulties the psychiatrist faces with relatives of the patients, outpatient care, family care, education of the public, and, finally, the mental hospital and civil emergencies.

In addition to this wealth of material, the book has a very thorough index and five appendixes. Each chapter has its own list of selected references. This comprehensive book provides signposts and gives direction to the young hospital physician. Dr. Linn's optimistic approach should inspire his readers, and the book should become a rallying point for all those interested in furthering the welfare of their patients, psychiatry, and themselves. If just one state hospital could be organized in accordance with the principles outlined in this book, American psychiatry would owe a great debt to both Dr. Linn and his publisher.

The Surgical Technic of Abdominal Operations. By Julius L. Spivack, M.D., LL.D., F.A.C.S., Associate Professor of Surgery, University of Illinois College of Medicine, Chicago. Fifth edition. Cloth. $17.50. Pp. 931, with 495 illustrations. Charles C Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill.; Blackwell Scientific Publications, 24-25 Broad St., Oxford, England; Ryerson Press, 299 Queen St., W., Toronto 2B, Canada, 1955.

This work, originally appearing in 1936, is an encyclopedic manual of technique for the abdominal surgeon. The author first covers certain basic surgical procedures, such as knot tying, and he develops his discussion of most of the recognized abdominal procedures by text directions and illustration. The book is thus suitable for the surgeon in training or for the practicing surgeon who wishes to refresh his memory of procedures he uses infrequently. The text is almost purely descriptive, often to the point of redundancy. The copious illustrations are clear, for the most part, though at times they are too diagrammatic to be of much practical use. One of the strongest points is the careful bibliographic annotation of the origins of the different techniques, which are becoming increasingly difficult to find. Most of the standard procedures are thoroughly and understandably depicted. There is little discrimination, however, so that much space is given to gastropexy and colopexy and too little to more recent and complex developments such as pancreaticoduodenectomy, porta caval shunts, and common duct reconstruction. Again, though multiple abdominal incisions, many of them obsolete, are described minutely, little attention is paid to thoracoabdominal incisions and no discussion of end ileostomy is offered at all. This volume should be of much interest as a reference book and a study manual. There are several contemporary works of a similar nature that, though not as inclusive, surpass it from the practical point of view.

Faith Is the Answer: A Pastor and a Psychiatrist Discuss Your Problems. By Norman Vincent Peale, D.D., and Smiley Blanton, M.D. Fifth printing. Cloth. $2.95. Pp. 243. Prentice-Hall, Inc., 70 Fifth Ave., New York 11, 1954.

After working together for many years at a clinic at the Marble Collegiate Church in New York City, a pastor and a psychiatrist joined forces to write this book, which is now in its fifth printing. The book is not directed primarily toward the cure of disease but toward the problem of keeping well people well. The authors believe that religion and psychiatry will make an ever-increasing joint contribution to this end in the coming years. The pastor, Norman Vincent Peale, has been heard also on the radio, television, and on the lecture platform. The psychiatrist, Smiley Blanton, is well known in the medical profession, having published books and papers in medical journals, and as a practitioner and member of various medical societies. Their objective is essentially the same: the renewal of faith when faith has been lost—faith in oneself, faith in one's fellow man, and faith in God. The book, which consists essentially of numerous accounts of personal incidents in which the foregoing objective has been attained, reads easily. Both authors write separate sections in the chapters entitled The Power of Faith; The Hidden Energies of the Mind; Fear, Worry, and Anxiety; Conscience and the Sense of Guilt; Self Criticism, Failure, and Success; Grief and Sorrow; Relief for the Lonely; Love and Marriage; and The Faith that Heals. Many persons no doubt will be able to find help and strength to solve many daily problems by reading this book.

Stuttering in Children and Adults: Thirty Years of Research at the University of Iowa. Edited by Wendell Johnson, Professor of Speech Pathology and Psychology, University of Iowa, Iowa City, assisted by Ralph R. Leutenegger, Assistant Professor of Speech Pathology, Michigan State University, East Lansing. Cloth. $5. Pp. 472. University of Minnesota Press, Minneapolis 14, 1955.

This monumental undertaking is divided into eight parts: General Orientation; The Onset of Stuttering; Nonfluency in the Speech of Early Childhood; Variations in Amount of Stuttering; Certain Aspects of the Personal Adjustments of Stutterers; Explorations of Certain Physical Approaches to Stuttering; For the Record; and Approaches to Stuttering Therapy. Most of the articles are elaborate scientific investigations of the ego psychology (conscious psychology) of the stutterer, but one or two of them attempt to explore the deeper mind of the stutterer. Dr. Johnson believes stuttering to be an anxiety state that the stutterer uses to avoid situations that cause him fear and anxiety. This apprehensive anxiety that characterizes the stutterer may be mild or may approach panic. The anxiety is aroused by sounds, words, listeners, and other situations in which the person has experienced stuttering in the past. Many factors decide just when and how this anxiety may arise, but the main feature of stuttering is an anxiety state that is aroused in certain situations that require speech. Dr. Johnson has done a splendid job in editing this book. It should be a great help to all those who work with persons with speech disorders.

These book reviews have been prepared by competent authorities but do not represent the opinions of any medical or other organization unless specifically so stated.

QUERIES AND MINOR NOTES

PREGNANCY AND DEAFNESS

To the Editor:—*A 31-year-old Italian woman had normal hearing until the seventh month of her first pregnancy in 1951. Postpartum examination revealed a 50% hearing loss on the right side. Following the second pregnancy diminution of hearing occurred in the left ear. There is no deafness in her family. She is now eight weeks' pregnant, and audiometric examination shows a loss of 50 db. on the right ear and loss of 20 to 40 db. on the left ear. Rinne test shows air conduction better than bone conduction. Is there a disease producing eighth nerve deafness that would be aggravated by pregnancy?*

Swan Burrus Jr., M.D., Jackson, Tenn.

Answer.—The only type of deafness that has been definitely connected with pregnancy is otosclerosis, which, in about one out of four pregnancies, becomes appreciably worse either during pregnancy or immediately following delivery. Otosclerosis typically causes a conductive hearing loss with fixation of the stapes. In some cases, cochlear nerve degeneration accompanies stapes fixation, and in still other cases there may be cochlear nerve deterioration due to otosclerosis without stapes fixation. This is known as labyrinthine otosclerosis. The latter type of case cannot be diagnosed as due to otosclerotic bone disease unless stapes fixation later occurs or unless there is a strong family history of otosclerosis. Since otosclerosis does occur sporadically, it is possible that the patient cited might have a labyrinthine otosclerosis, but there are no clinical criteria to differentiate labyrinthine otosclerosis, without stapes fixation and without a family history, from nerve deafness of idiopathic origin.

DINITROPHENOL CATARACTS

To the Editor:—*Will cataracts develop many years after dinitrophenol therapy has been discontinued?*

M.D., California.

Answer.—Twenty years ago dinitrophenol was introduced as a drug with the unusual property of painlessly reducing weight. Thousands of Americans eagerly took the new treatment. In a few weeks ophthalmologists began to see a new type of bilateral cataract. They promptly recognized the cause as a toxic substance, which proved to be dinitrophenol. Soon thereafter, dinitrophenol was taken off the market. It was found that, although most of the cataracts developed while the drug was being ingested, a comparatively few had lens changes after its consumption had been stopped. In no authentic case did cataracts become manifest later than eight months after the drug therapy was discontinued. It is so highly improbable that the drug could in any way change the metabolism of the lens after the lapse of years that dinitrophenol cataracts have neither been seen nor reported for several years. They do not exist.

AGLYCEMIA

To the Editor:—*Does aglycemia ever occur in human beings and, if so, under what circumstances?*

M.D., Illinois.

Answer.—Extremely low values of blood sugar occurring spontaneously have been described primarily in infants with abnormal carbohydrate metabolism and particularly in the presence of glycogenosis. In these patients, it is assumed that low blood sugar levels are secondary to the inability of the liver to liberate free glucose into the blood stream, because of the absence of the enzyme, glucose 6-phosphatase, which normally performs this function. Whether these reported instances represent marked hypoglycemia or aglycemia is difficult to decide, since the methods used for the determination of blood sugar are not entirely specific. Most blood sugar methods measure the reducing properties of glucose after preliminary precipitation of a greater or lesser proportion of possible interfering reducing substances other than glucose; hence, the hypoglycemic levels obtained in infants with glycogenosis could well represent aglycemia. Methods involving yeast fermentation are not sufficiently sensitive in this extremely low range. Recently, blood sugar levels in an infant with glycogenosis, were measured, using a specific enzymatic method for glucose. On several occasions, no measurable glucose was present in the patient's blood, the sensitivity of the method justifying the statement that less than 2 mg. of glucose per 100 ml. of blood could have been present. The remarkable paucity of symptoms in infants with glycogenosis and hypoglycemia was observed in this patient.

DESTRUCTION OF PINWORM EGGS

To the Editor:—*Recommendations for care of clothing and bedding of persons treated for Enterobius vermicularis (pinworm) include the stipulation that all fabrics in close contact with the patient be boiled daily or, if not boilable, that they be treated by soaking in ammonia solution. Would treatment of them in a home clothes dryer be adequate? If so, for how long and at what temperature?*

Michael Irvin, M.D., Tacoma, Wash.

Answer.—In experiments, ammonia, in accordance with usual recommendations, was not found effective for the destruction of pinworm eggs on clothing and bedding. Jones and Jacobs (*Am. J. Hyg.* Sect. D 33:88 [May] 1941) found that these eggs were invariably destroyed by dry heat at a temperature of 140 F. A manufacturer of home clothes dryers has said that the thermostat on their equipment is set for a mean temperature of 180 F. At the end of each cycle the thermostat cuts off at 205 F, and the heat within the dryer will even reach 212 F for perhaps half a minute. However, the effect of this amount of heat in the clothes dryer would be influenced by the degree of humidity in the dryer and the amount of moisture retained by the contents. Presumably, however, even after making allowances for these factors, it would appear that the conditions prevailing within the dryer would be effective for the destruction of pinworm eggs, provided, of course, that the above-mentioned temperatures actually penetrated all parts of the contents.

INCARCERATED HERNIA

To the Editor:—*Does omentum alone in an incarcerated hernia ever become strangulated and, as a result, infarcted or gangrenous? If so, would failure to operate in such a case be likely to lead to a fatal peritonitis, or would it probably fibrose and calcify?*

M.D., New York.

Answer.—Many of the signs and symptoms of incarcerated intestine can be produced by incarceration and strangulation of the omentum alone in a hernial sac. Moreover, strangulation and gangrene of a fat-covered femoral hernial sac, in which there are no abdominal contents, will also present clinical evidence indistinguishable from that of an incarcerated femoral hernia. Strangulation of the omentum does lead to infarction and gangrene. This dead tissue could become infected, but it is doubtful if it would lead to fatal peritonitis, since the neck of the sac would become sealed off and the local signs of abscess would indicate the need for prompt surgical evacuation. Areas of fibrosed omentum are not an uncommon finding in operations for large inguinal hernia and probably represent those cases of incarceration in which the blood supply was not completely impaired. Theoretically, it is possible for calcium to be laid down in some of these structures, but such a case has not been observed by this consultant.

The answers here published have been prepared by competent authorities. They do not, however, represent the opinions of any medical or other organization unless specifically so stated in the reply. Anonymous communications and queries on postal cards cannot be answered. Every letter must contain the writer's name and address, but these will be omitted on request.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JANUARY-APRIL 1956

Abstracts have been made of important articles in the following journals in the Current Medical Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by the Library of the American Medical Association to individuals in Continental United States and Canada who subscribe to its scientific periodicals and to members of the American Medical Association and its student organization. No charge is made to members, but the fee for other borrowers is 15 cents in stamps for each periodical. Three journals may be borrowed at a time for a period not exceeding five days. Thus most of these journals are accessible to the general practitioner.

*A. M. A. Archives of Dermatology. Chicago.
*A. M. A. Archives of Industrial Health. Chicago.
*A. M. A. Archives of Internal Medicine. Chicago.
*A. M. A. Archives of Neurology and Psychiatry. Chicago.
*A. M. A. Archives of Ophthalmology. Chicago.
*A. M. A. Archives of Otolaryngology. Chicago.
*A. M. A. Archives of Pathology. Chicago.
*A. M. A. Archives of Surgery. Chicago.
*A. M. A. Journal of Diseases of Children. Chicago.
Acta cardiologica. Brussels.
Acta chirurgica belgica. Brussels.
Acta chirurgica scandinavica. Stockholm.
Acta medica scandinavica. Stockholm.
Acta paediatrica. Uppsala.
Acta radiologica. Stockholm.
Acta tuberculosea belgica. Brussels.
American Heart Journal. St. Louis.
American Industrial Hygiene Association Quarterly. Chicago.
American Journal of Clinical Pathology. Baltimore.
American Journal of Digestive Diseases. New York.
American Journal of Gastroenterology. New York.
American Journal of the Medical Sciences. Philadelphia.
American Journal of Medicine. New York.
American Journal of Obstetrics and Gynecology. St. Louis.
American Journal of Ophthalmology. Chicago.
American Journal of Pathology. Ann Arbor, Mich.
American Journal of Psychiatry. New York.
American Journal of Public Health. Albany, New York.
American Journal of Roentgenol. and Radium Therapy. Springfield, Ill.
American Journal of Surgery. New York.
American Journal of Tropical Medicine and Hygiene. Baltimore.
American Practitioner and Digest of Treatment. Philadelphia.
American Review of Tuberculosis. New York.
American Surgeon. Baltimore.
Anales de la Facultad de medicina de Montevideo. Montevideo.
Anesthesiology. Philadelphia.
Annales chirurgiae et gynaecologiae Fenniae. Helsinki.
Annals of Allergy. St. Paul.
Annals of Internal Medicine. Lancaster, Pa.
Annals of Otology, Rhinology and Laryngology. St. Louis.
Annals of the Rheumatic Diseases. London.
Annals of Surgery. Philadelphia.
Antibiotic medicine. New York.
Applied Microbiology. Baltimore.
Archiv für japanische Chirurgie. Kyoto.
Archiv für klinische Chirurgie. Berlin.
Archiv für orthopädische und Unfall-Chirurgie. Munich.
Archives of Disease in Childhood. London.
Archivos médicos panameños. Panama.
Australasian Annals of Medicine. Sydney.
Australian and New Zealand Journal of Surgery. Melbourne.
Beiträge zur klinischen Chirurgie. Munich.
Beiträge zur Klinik der Tuberkulose. Berlin.
Blood. New York.
Blut. Munich.
British Heart Journal. London.
British Journal of Cancer. London.
British Journal of Dermatology. London.
British Journal of Haematology. Oxford.
British Journal of Plastic Surgery. Edinburgh.
British Journal of Radiology. London.
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SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "ab," abstracts; the asterisk (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word with the following exceptions: Foundations, Lectures, Moving Pictures, and Prizes, under "F," "L," "M," and "P" respectively. "Book Reviews," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

For the author index see page 46.

A

ACTH: See Corticotropin
AFC VIRUS: See Adenoidal-Pharyngeal- Conjunctival Virus
ABANDONMENT OF PATIENT: See Medicolegal Abstracts at end of letter M
ABDOMEN
abdominoperineal proctosigmoidectomy preserving sphincter, [Bacon] *628
acute conditions in children, Brazil, 1252
concomitant pain in back, [Lewin] 1257—C
foreign bodies, artery forceps removed 5 days later, Sweden, 413
surgery, carbohydrate metabolism after, Peru, 895
surgery, endometriosis on laparatomy scar 10 years later, [Fernandez-Ruiz] 1266—ab
surgery, fat embolism after, [Schofield] 1368—ab
surgery in old age (Swiss society discusses risk) 316; (principles and safeguards) [Gilchrist & de Peyster] *1375
surgery, pancreatitis after, [Kern] 911—ab
surgical wound healing with or without dressings, [Palumbo & others] *253
tuberculosis in children, x-ray diagnosis, [Dittrich] 986—ab
ABORTION
kidney tubular necrosis after, [Bull] 1434—ab
law, recommend changes, United Kingdom, 702
ABRASION, Therapeutic: See Planing
ABSCESS
of liver (traumatic), aspiration and emetine for, India, 992
of lung, endocavitary aspiration for, [Monaldi] 1367—ab
of lung, operation, France, 1163
ABSENTEEISM: See Industrial Health, workers absenteeism
ACCIDENTAL DEATH: See Medicolegal Abstracts at end of letter M
ACCIDENTS
Automobile: See Automobiles
catastrophic, statistics, 572
control to prevent chronic illness, [Scheele] *1114; 1145—E
freak, [Jones] *318
Industrial: See Industrial Accidents
Insurance: See Medicolegal Abstracts at end of letter M
railway, compensation for hysteria after, United Kingdom, 502
ACCLIMATIZATION: See Climate
ACETAZOLAMIDE
N.N.R., 1142
potassium surcharge with, Switzerland, 1429
sodium, N.N.R., 1143
toxicity: kidney lesions, [Glushien & Fisher] *204
toxicity: thrombocytopenia, [Reisner & Morgan] *206
treatment of cirrhosis, Peru, 134
treatment of diabetes, Austria, 499
treatment of epilepsy, [Lombroso & others] *268
treatment of nephrosis, Austria, 794
ACETRIZOATE, SODIUM
in gastrointestinal roentgenoscopy, [Davis & others] *373
***di*ACETYL MORPHINE (heroin)**: See Morphine
2-ACETYLAMINO-5-NITROTHIAZOLE
oral trichomonacide, (Flenti) 715—ab
N-ACETYL-*p*-AMINOPHENOL
pediatric antipyretic-analgesic, [Cornely & Ritter] *1219
treatment of rheumatism compared to salicylamide, (reply:) [Salamon] 705—C
ACETYLCHOLINE
liberation at site of allergy, India, 993
sensitivity in auriculotemporal syndrome, [Gardner & McCubbin] *272
treatment of ventricular fibrillation, [Burmeister] 709—ab
ACETYLSALICYLIC ACID (Aspirin)
effervescent, for recurrent renal calculi, [Baker & Connelly] *1106
toxicity: coma; peripheral nerve lesions from, [Olsen] *39
toxicity; gastric hemorrhage, United Kingdom, 897
treatment of hemorrhagic colitis, Switzerland, 1350
treatment of recurrent urolithiasis, [Prien & Walker] *255; [Baker & Connelly] *1106
ACETYLSALICYLIC ACID—Continued
vs. salicylamide as analgesic and antirheumatic, (replies) [Salamon] 703—C; [Margolis] 899—C
ACHALASIA
of esophagus, surgery for, [Sweet] 1174—ab
ACHROMYCIN: See Tetracycline
ACID: See under name of specific acid as Acetylsalicylic Acid
ACNE
treatment, diethylstilbestrol in adolescence, 1184
ACRONIZE: See Chlortetracycline, food preservative
ACTINOMYCIN C
inhibits growth of Ehrlich and Walker carcinomas in rats, United Kingdom, 584
toxicity: agranulocytosis fatal, [Janbon] 605—ab
treatment of Hodgkin's disease, [Trounce] 507—ab
treatment of malignant adenopathies, [Croizat] 604—ab
ACTINOMYCOSIS
of breast, India, 74
ADAMS-Stokes Syndrome: See Heart, block
ADENOIDAL-PHARYNGEAL-CONJUNCTIVAL-VIRUS
epidemic keratoconjunctivitis relation to, [Ormsby] 331—ab
ADENOIDECTOMY
bleeding after, vitamins K and C for, [Harkins] 1536—ab
ADENOMA
pancreatic, B-cell, symptoms, [Pedrazzini] 908—ab
pancreatic, postgastrectomy symptoms from, [Zollinger & Williams] *367
thyroid, genesis in siblings, [Zondek] 1260—ab
toxic adenomatous goiter, I^{131} for, [Cook] 507—ab
ADOLESCENCE
acne in, diethylstilbestrol for, 1184
Wood's glass to detect tinea capitis in, 424
ADRENALIN: See Epinephrine
ADRENALS: See also Cushing's Syndrome
adrenogenital syndrome, Italian congress discusses, 582
cancer, nonfunctioning, Peru, 1164
cortex function in hypothermia, [Egdahl] 722—ab
cortex function in schizophrenia, [Bliss] 81—ab
cortex insufficiency, rapid test for, [Perlmutter] *117
cortex insufficiency, treating during surgery, [Howland & others] *1271
cortex surgery, problems and replacement therapy, [Gonzerts] 1264—ab
insufficiency in heart disease and rectum cancer, (Diagnostic Problems) [Frazier] *774; (comment) [Ray] *773
role in nutrition, especially vitamins, Italy, 894
surgery, adrenalectomy in breast cancer, [Hughes-Jones] 327—ab; (plus oophorectomy) [Baston] 942—ab; [Cuningham] 1174—ab
tuberculous hypocorticalism, [Besta] 907—ab
tumor in Conn's syndrome, [Chalmers] 1432—ab
tumors, nonfunctioning, Peru, 1164
ADRENOCORTICOTROPIC HORMONE: See Corticotropin
ADRENOSEM SALICYLATE: See Carbazochrome
ADVISORY BOARD FOR MEDICAL SPECIALTIES
established, 978; [Kirklin] *1327
AEROLONE: See Isoproterenol
AEROPLAST: See Vibesate
AGAMMAGLOBULINEMIA: See Blood
AGE
factor in hemoglobin level in congenital heart disease, [Shephard] 1260—ab
factor in influenza antibodies of serum, postepidemically, [Hennessy] 329—ab
factor in sweating intensity, Switzerland, 414
in estimating operative risk, [Moyer & Key] *853
motion sickness varies inversely with, *735; (correction) 1081
of retirement, Nuffield Foundation study, United Kingdom, 798
AGGLUTINATION
auto-, complicating lupus erythematosus, 89
AGITATED Depression: See Psychosis, manic depressive
AGRANULOCYTOSIS
etiology: actinomycin C, fatal, [Janbon] 605—ab
etiology: chlorpromazine, (Council report) 287
AIR
accidental injection into vein, aspirating from heart, 817
conditioner in operating room, for explosive atmospheres, (reply:) [Walter] 152
embolism after antral lavage, [Thomson] 719—ab
filter of value in pollen asthma? 921
more dust and less smoke over Great Britain, 702
pollution in lung cancer etiology, Italy, 1164
pollution, USPHS research, 129
AIR FORCE: See Aviation, U. S. Air Force
AIRPLANES: See Aviation
AKERS' HAIR AND SCALP CLINICS, Dr. Kelvin charged for associating with, United Kingdom, 897
ALAMASK
to deodorize toilet rooms, 1184
ALARM
for enuresis, psychological harm from? 1374
ALASKA
mental disorders in, Dr. Lull writes to Senate on proposed legislation, 1235
ALBERT EINSTEIN COLLEGE OF MEDICINE
dedicated, 383
ALBOMYCIN
antibiotic discovered in Russia, 226; [Gause] 332—ab
ALBUMIN: See also Radio-Iodinated Serum Albumin
tannate effect on poliomyelitis virus excretion after oral immunization, [Koprowski & others] *954
ALBUMINURIA
in children drinking fluoridated and nonfluoridated water, [Schlesinger & others] *21
no other symptoms, differential diagnosis, 1099
ALCOHOL
diet deficiency and recourse to, France, 1163
in etiology of larynx cancer, (Wynder & others] *1381
Ingestion (standardized), electroencephalogram correlated with blood alcohol, [Holmberg] 81—ab
Inhalation in postoperative lung edema, [Weyl] 149—ab
Intake and erythrocyte aggregation, [Forsander] 813—ab
sensitivity in Hodgkin's disease, [Godden & others] *1274
vodka relieves heart condition better than whiskey, why? 610
ALCOHOLISM
cirrhosis complicating, hepatic coma in, [Benhamou] 137—ab; (also protein nutrition in) (Council report) [Davidson] *290
decrease in alcoholic patients, Ill., 402
electroencephalogram correlated with blood conditions after alcohol ingestion, [Holmberg] 81—ab
etiology in young men [Wellman] 81—ab
gastric ulcer and [Navratil] 138—ab
gastritis (chronic) relationship, United Kingdom, 1430
in etiology of magnesium deficiency syndrome, (Council report) [Flink] *1408
more pronounced after antihistamines? 818
peripheral nerve lesions after coma in, [Olsen] *39
rehabilitation commission, new offices, Vt., 571
treatment, lipotropic agents, (Council article) [Gabuzda] *969
treatment, liver extract, France, 694
ALDOSTERONE (Electrocortine)
aldosteronism in pregnancy, potassium chloride for, N. Z., 229
aldosteronism, new entity, [Conn] 904—ab
in urine, and hypothalemia, Switzerland, 1165
ALIMENTARY TRACT: See Gastrointestinal Tract
ALKAVERVIR
treatment of hypertension evaluated, variables in [Shapiro] *30

ALKALI
burns of esophagus, management, [Carver & others] *1447
ALLERGY
air filter for pollen asthma? 921
alcohol sensitivity in Hodgkin's disease, [Godden & others] *1274
anaphylactoid purpura, [Sánchez Medal] 1002—ab
antiseptic soap, [Blank] *1225
autosensitization in varicose eczemas, [Haxthausen] 683—ab
chemical changes at site of manifestations, [Solis] 983
chloropromazine, sensitivity, (dermatitis in nurses and pharmacists, England) 74; [Asher] *1281; (laryngeal edema) [Brill] 1355—C
dermatitis from plastics, detergents, Dacron and Orlon, desensitize? 1438
dermatitis from stockings, United Kingdom, 1256
facial tissues with urea-formaldehyde resin, [Peck & Palitz] *1226
fever following triple vaccine, 1004
hyposensitization for hay fever, Sweden, 896
in etiology of occupational dermatoses, [Klauder] *1412
nasal, food causes, [Dodlacki] 1436—ab
national advisory council, surgeon general appoints, 989
National Institute of Allergy and Infectious Diseases established, 578; (Dr. Davis, associate director) 1423
neomycin dermatitis, [Epstein] 1355—C
PAS side effects, Switzerland, 1428
PAS and streptomycin sensitivity fatal, [Hansen] 509—ab
penicillin, guest editorial by Drs. S. M. and A. R. Feinberg, 778—E
penicillin, nonfatal and fatal, [Peters] 1178—ab
serum sickness and penicillin reactions, cortisone and ACTH for, [Fitzgerald] *883—ab
skin test for industrial compounds, polyvalent sensitivity develops, [von Haam] 683—ab
treatment, prednisone, [Feinberg & Feinberg] *264
ALLOXAN
treatment fails in islet-cell tumor with hyperinsulinism, [Fisher] 354—ab
ALPHAPRODINE HYDROCHLORIDE
to supplement (plus Lortan) nitrous oxide-oxygen-thiopental anesthesia, [Foldes & others] *168
ALSEROXYLON: See Rauwolfia serpentina
ALTITUDE
effect on fertility, Peru, 134
effect on respiration, Peru, 315
high, lung edema in, Peru, 898
ALUDRINE: See Isoproterenol
AMBENONIUM CHLORIDE
treatment of myasthenia gravis, [Westerberg] 998—ab
AMBULANCES
problems in N.H.S., United Kingdom, 1329
AMEBIASIS: See also Colitis, amebic
atypical forms, Austria, 1148
diagnosis, therapy, United Kingdom, 996
intestinal: incidence, symptoms; arsthinol therapy, [Brown & others] *360; 393—E
intestinal, India, 1164
treatment, carbarsone; hepatitis from, [Nelson] *764
treatment, fumagillin and erythromycin, [Jung] 1096—ab
treatment status, (Council report) *1230
AMENORRHEA
treatment, progesterone, Israel, 994
AMERICAN. See also list of Societies and Other Organizations at end of letter S
Boards, [Kirklin] *1327; (diplomates by medical school) (Bureau article) [Dickinson] *1327
Cancer Society's program, doctors' opinions on, (Miscellany) *1171
Heart Ass'n donates Harvey's book on circulation to John Crerar Library, [Katz] *1137
Hospital Assn., (brochure on disaster planning), 976—E; (to continue Liaison Committee with A. M. A.) 1322
Legion, A. M. A. relations, President Hess' Page 1474
Medical Education Foundation: See Foundations
AMERICAN MEDICAL ASSOCIATION
American Legion relations, (President Hess' Page) 1474
American Medical Education Foundation: see Foundations
Annual Congress on Medical Education and Licensure, 52nd (program), 54; 120—E; (report) 978; (papers read) [Stone] *1298; [Weichselbaum] *1303; [Comroe] *1323
Board of Trustees, (commends President Eisenhower on health program) 678; (actions by) 1322; (propose amendment to W. M. A. Constitution) 1323; (portraits) preceding 1439
Bureau of Investigation pamphlet on quacks, 1333
AMERICAN MEDICAL ASSOCIATION—Continued
Chicago Meeting, program, 1475
Committee on General Practice Prior to Specialization appointed, 1322
Committee on Geriatrics appointed, 1322
Committee on Medical Aspects of Automobile Injuries and Deaths to be enlarged, 1322
Committee on Research, grants-in-aid, 1147
committee to review Joint Commission on Accreditation of Hospitals, requests physicians' comments, 879
Council on Industrial Health, annual congress, 55—E; (program) 56; (report) 676
Council on Medical Education and Hospitals, Internship and residency number, 159:251, Sept. 24, 1955; (supplement list and corrections) 160:212, Jan. 21, 1956.
Council on Mental Health, Dr. Plunkett to serve on Joint Commission on Mental Illness and Health, 879
Council on National Defense, services available from, 1413
Council on Pharmacy and Chemistry, change in operation; list trade names, 50
Directory-Biographical Department, P. E. Mohr, director, 879
Distinguished Service Award, request nominations, 1410—E
exchange visits with B. M. A. members, 1352
Finance Committee selects investment advisors, 1147
forms Physicians' Advisory Committee for television, radio, and motion pictures, 1147; 1322
headquarters, invite visitors, 1486
JOURNAL, (copies of index available) 121; (survey to be made on physicians' opinions of) 1322
Law Department, (study of professional liability insurance) 393—E; [Medicine and the Law] *395; (survey on committees for review of medicolegal testimony) [Medicine and the Law] *1334
meetings, admission to exhibits limited, 1322
membership, address required before membership card issued, 27
National Medical Defense Conference: See Civilian Defense
Officers, 1955-1956, (list of) 1477; (portraits) preceding 1439
1956 radio plans, 286
opposes questionnaire on President Eisenhower, 52—E
physicians' attitudes toward voluntary health insurance, survey, 169—E
President-Elect Murray, portrait, preceding 1439
President's Page, monthly message, (Jan.) 293; (Feb.) 675; (March) 1146; (April) 1474
Program of Chicago Meeting, 1475
public opinion survey about doctors, 170—E; 671
QUARTERLY CUMULATIVE INDEX MEDICUS, Volume 54 available, 978
radio transcription on "Common Cold," 1333
represented on Blue Shield Commission, 1322
reprints and booklets available from, 295; 296; 781; 879; 1235; 1333
Reviews of Medical Motion Pictures available, 981
Salk vaccine committee appointed, 1333
Scientific Assembly program, Chicago meeting, 1488
Scientific Exhibit, Chicago Meeting, 1507
Section on Gastroenterology and Proctology, (Chairman's Address) [Bacon] *828
Section on General Practice, (Chairman's address) [McDaniel] *1193
Section on Laryngology, Otology and Rhinology, (Chairman's address) [Davison] *1165
Section on Military Medicine, (Chairman's address) [Rankin] 159:1169, Nov. 12, 1955
Section on Obstetrics and Gynecology, (Chairman's address) [Falls] *251
Section on Physical Medicine and Rehabilitation, (Chairman's address) [Schmidt] 159:1167, Nov. 12, 1955
Section on Preventive and Industrial Medicine, (Chairman's address) [Phair] 159:1165, Nov. 12, 1955
Section on Surgery, General and Abdominal, (Chairman's address), [Zollinger & Williams] *367
Section on Urology, (Chairman's address) [Higgins] *10
Sections, (portraits of Chairman and Secretaries) preceding 1439; (program) 1489; (exhibits) 1509
Student A. M. A.: See Students, Medical
supports proposed legislation on care of mental disorders in Alaska, 1235
Technical Exposition, Chicago Meeting, 1520
television, (cosponsors "March of Medicine") 1147; (color TV at Chicago Meeting) 1505
to continue Liaison Committee with American Hospital Ass'n., 1322
to gather absenteeism statistics for industry, 676
to present science fair awards, 781
to publish CHRONIC ILLNESS NEWS LETTER, 292—E
AMERICAN MEDICAL ASSOCIATION—Continued
TODAY'S HEALTH available at discount to nurses, through Woman's Auxiliary, 295
Washington Office report of hearings on social security, 1056—E; 1058
Woman's Auxiliary: See Woman's Auxiliary
AMINO ACIDS
balance, value of dietary supplements, 608
in semen at various levels of infertility, [Tyler & Singher] *91
AMINOACIDURIA
in children with rickets and tetany, France, 1330
prednisone effects on, Switzerland, 414
proteinemia with, in children, France, 1530
p-AMINOBENZENE-SULFAMIDOISOPROPYL-THIODIAZOL
treatment of diabetes mellitus, [Loubatières] 1596—ab
D-4-AMINO-3-ISOXYAZOLIDONE: See Cycloserine
AMINOPHERASE: See Transaminase
AMINOSALICYLATE, POTASSIUM
N. N. R., 1143
p-AMINOSALICYLIC ACID (PAS)
sodium salt plus streptomycin and isoniazid in renal tuberculosis, [Lattimer & others] *514
toxicity; sensitivity, fatal, [Hansen] 509—ab
toxicity, side-effects, Switzerland, 1428
treatment (combined) in tuberculosis, [Hoyle] 707—ab
treatment of bone and joint tuberculosis, [Campos] 596—ab; [Smith] 597—ab
treatment plus streptomycin in pelvic tuberculosis, 152
treatment plus streptomycin in tuberculosis, [Tucker] 322—ab; (or plus isoniazid) 323—ab; (United Kingdom) 1166
treatment plus streptomycin, isoniazid and early surgery in tuberculosis, [Allen] 508—ab
AMIPHENAZOLE
barbiturate antagonist, [Shaw] 720—ab
morphine with, for pain of terminal cancer, United Kingdom, 1351
AMMONIUM COMPOUNDS
Tetraethyl—: See Tetraethylammonium Chloride
treatment of cirrhosis, magnesium deficiency after, (Council report) [Flink] *1106
AMMUNITION: See Munitions
AMOBARBITAL
for sleep therapy, with chlorpromazine and phenobarbital in ophthalmology, France, 1428
AMODIAQUIN HYDROCHLORIDE
treatment of discoid lupus erythematosus, [Lerper] 1001—ab
treatment status in amebiasis, (Council report) *1230
AMPHETAMINE. See also "Benzedrine" under Medicolegal Abstracts at end of letter M
poisoning, United Kingdom, 1430
sulfate and Rauwolfia for obesity, [McNair] 331—ab
AMPLIFIERS
for telephone, portable, [Hosmer] *285
AMPUTATION
for pigmented villonodular synovitis in finger? 424
of legs in old age, dynamic exercises after, [Eisert] 1266—ab
of wrong finger, patient awarded damages, United Kingdom, 701
refrigeration for, [Crossman] 1002—ab
AMYLOIDOSIS
complications: polyneuropathy, [Sullivan] 681—ab
ANALGESIA
meperidine (continuous drip) adjunct to thiopental sodium-nitrous oxide-oxygen anesthesia, [Ausherman & others] *175
pediatric, N-acetyl-p-aminophenol, [Cornely & Ritter] *1219
salicylamide evaluated, (replies) [Salamon] 703—C; [Margolis] 800—C
statistical studies: evaluating double blind-fold technique, (reply) [Best] 586—C
ANAPHYLAXIS: See Allergy
ANDROGENS
free testosterone vs. methyltestosterone treatment, 1268
testosterone for breast cancer, survival after, Brazil, 992
testosterone, large doses for male infertility, [Charny] *98
treatment, Belgium, 1348
treatment in pregnancy, infant hermaphroditism after, [Hoffmann] 1535—ab
treatment of premenstrual eczema, 341; (reply) [Greenblatt] 1186
ANEMIA
after gastrectomy, [Bolvin] 596—ab
aplastic (Fanconi's), splenectomy in, [Francis] 145—ab
aplastic (fatal) after Nutarone, [Isaacson & others] *1341
aplastic, from intravenous Au[198], [Schoolman & Schwartz] *161
complicating infection, iron metabolism in, [Bush] 804—ab
Cooley's: See L. pinocytosis, hereditary

ANEMIA—Continued
erythroblastic, with thymus tumor, (Diagnostic Problems) [Ramos] *1317; (comment) [Loeb] *1319
hemolytic, acquired, [Weiner] 1173—ab
hemolytic, acquired; prednisone for, [Sussman & Dordick] *285; (Switzerland) 414
hemolytic, from intrinsic or extrinsic changes in corpuscles, Belgium, 1349
in pregnancy, Ireland, 797
iron deficiency, colloidal iron saccharates for, Austria, 1886
iron deficiency, in infants, guest editorial by Dr. Jackson, 976—E
Mediterranean: See Leptocytosis, hereditary
megaloblastic, after partial gastrectomy and gastroenterostomy, [Badenoch] 321—ab
sickle-cell, in children, clinical signs, [Scott] 691—ab
ANEMIA, PERNICIOUS
achylia gastrica and achlorhydria differentiated by radioactive vitamin B_{12}, [MacLean] 79—ab
in South African Bantu, [Woods] 885—ab
treatment, intranasal vitamin B_{12}, [Monto] 137—ab
ANESTHESIA
death from, United Kingdom, 699; (hexobarbital) 1532
Dramamine, Thorazine and pentobarbital for nausea, vomiting and retching after, [Knapp & Beecher] *376
ether with nitrous oxide in cesarean sections, [McNally & Fitzpatrick] *1005
explosion hazard from static and wired electricity, [Cole] 135—C; (reply) [Van Atta] 703—C
for appendectomy after myocardial infarction, (reply) [Baldwin] 728
for cardiac catheterization in children, [Fieldman] 516—ab
for cesarean sections, [McNally & Fitzpatrick] *1005
for mammary artery ligation for myocardial infarction with angina pectoris, [Muzzulini] 149—ab
Hawaiian Society of Anesthesiologists formed, 786
in etiology of surgical cardiac arrest, [Briggs & others] *1439
intratracheal, granulomas after, (reply) [Lorie] 90
local (new), trimethylene dimercaine, India, 1164
nitrous oxide-oxygen-thiopental, levallorphan-alphaprodine supplements, [Foldes & others] *168
nitrous oxide-oxygen-thiopental sodium, continuous drip meperidine supplement, [Ausherman & others] *175
nitrous oxide-thiopental for minor procedures? 518
nylon clothing safe around? 88
pyridoxine in, for ambulatory fracture patients, Peru, 134
spinal, in cesarean sections, [McNally & Fitzpatrick] *1005
spinal, in vaginal deliveries, [Elkins] 513—ab
spinal, neurologic complications, Peru, 895
steroid, [Gordan] 1002—ab; [Murphy] 1097—ab
topical, for endoscopy, hexylcaine, [Orkin & Rotenstine] *1465
trends in, United Kingdom, 700
ultrashort, with baytinal, [Westernborn] 516—ab
ANEURYSM
abdominal aorta involving renal artery, renal function after surgery for, [Ellis] 595—ab
abdominal aorta, resect and graft, [Etheredge] 510—ab
aortic, [Brindley] 1179—ab
aortic, after resection for coarctation, [Martin & others] *871
aortic arch, total excision, [Cooley] 323—ab
ANGER
uncontrollable, is there a biological component; how manage? 320
ANGINA PECTORIS
complicating myocardial infarction, anesthesia for surgery in, [Muzzulini] 149—ab
effects of Rauwolfia in, [Lewis & others] *622
glaucoma contraindicate nitrites for? 1004
pneumoperitoneum to differentiate from hiatal hernia, [Maisel & Borger] *868
surgical treatment, de-epicardialization, [Harken] 1095—ab
treatment, heparin, [De Matteis] 507—ab
ANGIOGRAPHY: See Blood Vessels, roentgen study
ANIRIDIA
probability in descendants of children of afflicted man; is it sex-linked? 423
ANOMALIES: See under names of specific organs as Heart
ANOSCOPE
rotatable, improved, [Abramson] *874
ANOXIA: See Oxygen deficiency
ANSOLYSEN: See Pentolinium Tartrate
ANTACIDS
milk compared to Sustagen, [Winkelstein & Schweiger] *1111
ANTEPAR: See Piperazine citrate
ANTHELMINTICS
evaluation, France, 695
ANTHRAX
from goat hair in coat linings, 52—E; (reply) [Gold] 1091—C
ANTIBIOTICS: See also under specific names
bacterial resistance, serial subculture in mixtures effects on, [Molomut & others] *967
broad spectrum, for fistulating bone tuberculosis with mixed infection, [Behrendt] 79—ab
for animals used for meat dangerous? 1004
hospital cross infection control with, England, 225
nutrition relation, [Grande] 1366—ab
senile effect on animals, France, 580
to prevent measle complications, United Kingdom, 896
toxicity; enterocolitis fatal, [Cuningham] 1175—ab
toxicity; micrococcic enteritis fatal, (Denmark) 412; (in surgical gynecology) [Baca] 810—ab
treat gingival sulcus to prevent postextraction hyperemia, [Bender] 896—ab
treat subacute bacterial endocarditis in patient with rheumatic history and fever? 689
treatment, differential selection, [Robitzek] 1534—ab
treatment of anthrax, 52—E; (reply) [Gold] 1091—C
treatment of fibrocystic pancreas, [di Sant'-Agnese] *846
treatment of genital tuberculosis in female, [Halbrecht] 715—ab
treatment of intestinal diverticulitis, 921
treatment of peritonitis after acute appendicitis, 921
treatment of purulent meningitis, [Aarsvold] 1265—ab
treatment of subacute bacterial endocarditis, [Henriksen] 802—ab
treatment plus cocarboxylase in severe tuberculosis, [Petruccioli] 1262—ab
treatment plus corticosteroids in tuberculous pericarditis, France, 1162
treatment plus Omnadin in surgery, [Timmer] 325—ab
treatment status in amebiasis, (Council report) *1230
ANTIBODIES
Complement: See Complement
deficiency syndrome; agammaglobulinemia, [Barandun] 1365—ab
Influenza, at different ages, postepidemically, [Hennessy] 320—ab
influenza, response to saline and oil vaccines, M.R.C. report, [Stuart-Harris] 321—ab
poliomyelitis, after oral immunization with attenuated virus, [Koprowski & others] *954
poliomyelitis, in newborn infant after intrauterine infection, [Sheckeley & Habel] *465
red blood cells coated with, in ulcerative colitis, [Lorber] 594—ab
ANTICOAGULANTS: See also under specific anticoagulants
to prevent embolism in mitral stenosis, [Varela de Seijas Aguilar] 591—ab
treatment of arteriosclerosis, [Raynaud] 591—ab
treatment of axillary vein occlusion, [Marks] 802—ab
treatment of coronary disease, Norway, 583
treatment of myocardial infarction, [Manson] 802—ab; (Austria) 1426
treatment of thromboembolism, [Olwin] *1101
ANTIGENS
pertussis, non-cellular; epidemiology, [Felton] 146—ab
ANTIHISTAMINES: See also under specific antihistamines
augment intoxication? 818
injectable, to prevent and treat transfusion reactions, N.N.R., 777
treatment of hay fever, priapism from? 1184
treatment of nausea and vomiting in pregnancy, (Council report) *208; [Lebherz] 420—ab
ANTIHYALURONIDASE
streptococcal, in sera in rheumatic fever, [Harris] 1096—ab
ANTISEPTICS
in soap, allergy to, [Blank] *1225
ANTISOCIAL BEHAVIOR
as criteria for not transfering mental patients to chronic disease facilities, [Shindell & Cornfield] *1121
ANTISTREPTOLYSIN
in sera in rheumatic fever, [Harris] 1096—ab
ANTRENYL: See Oxyphenonium
ANURIA: See Urine suppression
ANXIETY
gastrointestinal disturbances with, chlorpromazine for, [Asher] *1281
AORTA
Aneurysm: See Aneurysm
coarctation, aneurysm and endarteritis after resection for, [Martin & others] *871
coarctation with congestive heart failure in infancy, [Lang] 1176—ab
AORTA—Continued
interrupt circulation by hibernation and hypothermia, [Parola] 910—ab
obstruction, bypass graft between splenic and iliofemoral arteries, [Warren] 714—ab
puncture from refilling artificial pneumothorax, United Kingdom, 1256
roentgen study (retrograde) to diagnose congenital heart disease; [Singleton] 328—ab
roentgen study to diagnose lung sequestration, [Kenney & Eyler] *1464
stenosis, aortoiliac, vascular hemodynamics, [Haimovici] 807—ab
stenosis of isthmus in infants, diagnosis; therapy, [Gruner] 243—ab
stenosis of isthmus, symptoms; surgery for, [Derra] 909—ab
AORTIC ARCH Aneurysm: See Aneurysm
AORTIC VALVE
regurgitation in prognosis of subacute bacterial endocarditis, [Mendelson & others] *437
APHASIA
retraining words available from Bellevue Medical Center, 816
APICOLYSIS: See Lungs collapse (apical)
APOPLEXY: See Brain hemorrhage
APPARATUS
electronic, to measure therapy in paralysis agitans, [Agate & others] *532
intravenous drip indicator, United Kingdom, 502
transilluminators and retractors, [Berens] 159; 1532, Dec. 17, 1955; (correction) 160; 492, Feb. 11, 1956
APPEL, KENNETH E., and Bartemeier, L. H., guest editorial: Joint Commission on Mental Illness and Health, 392—E
APPENDECTOMY
after myocardial infarction, anesthesia for, (reply) [Baldwin] 728
APPENDICITIS
acute, in children, Brazil, 1272
antibiotics for peritonitis after, 921
APPENDIX
knot, closed-loop obstruction of ileum from; [Mikal & Byers] *19
APRESOLINE: See Hydralazine
ARACHNOIDITIS
adhesive, from detergents and chemicals, [Hurst] 516—ab
ARALEN: See Chloroquine
ARGENTAFFINOMA: See Carcinoid
ARMED FORCES
A.M.A. members, request address, 37
correspondence course on x-ray for, 1156
dependents, civilian doctor in care of, (reply) [Hahn & Raffensperger] 899—C
motion sickness drugs evaluated on transport ships, *755; (correction) 1081
tuberculosis in, (Norway) 583; (Finland) 892
ARMS
exoskeletal splithook prostheses for traumatic tetraplegia, [Nyquist] *761
paralysis from intramuscular injection by nun, surgeon's responsibility, France, 1163
prolapse, in presentation of fetus, Austria, 1347
ARMY, UNITED STATES
consultant committees to assits surgeons, 888
first lieutentant physician promoted, 691
laboratory and research center moved from Tokyo to Camp Zama (photo) 1156
ARRHYTHMIA: See also Tachycardia; Ventricular Fibrillation
vagal stimulation and hypoxia effect on, [Jacoby] 516—ab
ARSENIC
compound for tropical eosinophilia, India, 686; 993
compounds in amebiasis, status, (Council report) *1230
ARSTHINOL
treatment of intestinal amebiasis, [Brown & others] *360
ART: See also Physicians, avocations
exhibit, schizophrenic, England, 74
fresco in Rikshospital in Oslo presents Hippocrates and Leonardo da Vinci, 583
"Professoren Collegium" of U. of Vienna, 19th century, (photo) 405
ARTERIES
aortoiliac stenosis, vascular hemodynamics, [Haimovici] 807—ab
basilar thrombosis with softening of cerebellum and brain stem after neck manipulation, [Ford] 1264—ab
bronchial vascularization in absence of pulmonary artery, [Broustet] 147—ab
calcification in infants, myocardial infarction from, [Traisman] 915—ab
choroidal (anterior) occlusion for Parkinsonism, [Cooper & others] *1444
coronary: See also Angina Pectoris; Arteriosclerosis; Thrombosis, coronary
coronary anomaly simulating patent ductus arteriosus, [Davis & others] *1047
coronary disease, anticoagulants for, Norway, 583
coronary disease, blood donations safe after? 1268
coronary disease, cholecystectomy in, [Keys] 713—ab

ARTERIES—Continued
coronary disease differentiated from hiatus hernia by pneumoperitoneum, [Maisel & Horger] *868
coronary disease (early), hazard of electric shock therapy in, 339
coronary disease, Rauwolfia effects on, [Lewis & others] *822
coronary disease relation to cholesterol and diet England, 313
coronary disease relation to peptic ulcer, England, 313
coronary disease, xanthine derivatives in, N.N.R., 51
coronary insufficiency in physician 39, 3 years ago, tennis contraindicated? 342
coronary ligation and occlusion of cardiac vein, [Sideris] 712—ab
coronary occlusion relation to myocardial infarction, [Snow] 245—ab
cranial, pulse volume in headache, [Brazil] 1535—ab
grafts, seamless synthetic, [Sanger & others] *1403
iliofemoral reconstruction, in arteriosclerosis obliterans, [Hoye] 1175—ab
mammary ligation in myocardial vascular disturbances, [Battezzati] 715—ab
mammary ligation to revascularize myocardium after infarction, anesthesia for, [Muzzulini] 149—ab
occlusion (temporary), pneumatic cuff for, [Gardner & Salmoiraghi] *1224
oxygen therapy by, Austria, 694
peripheral disease, oxygen for, [Judmaier] 911—ab
pulmonary absent, bronchial vascularization in, [Bronstet] 147—ab
pulmonary hypertension with ventricular septal defects, pump-oxygenator for surgery, [DuShane & others] *950
renal, abdominal aorta aneurysm involving; renal function after surgery for, [Ellis] 595—ab
renal occlusion causing hypertension, [Poutasse] 1435—ab
splenic and iliofemoral bypass graft for aortic or iliac obstruction, [Warren] 714—ab
subclavian compression can cause hand numbness, (reply) [Ehni] 922
ARTERIOSCLEROSIS
cerebral, sympathectomy indications in, [Murakami] 599—ab
coronary, ulcer diets increase chance of? 424
Hartford Foundation research grant at Harvard U. 216
hypercholesterolemia relation, N.N.R., 670
obliterans, iliofemoral reconstruction in, [Hoye] 1175—ab
of legs, grafts for, [Horton] 1175—ab
treatment, anticoagulants, [Raynaud] 591—ab
ARTERITIS: See also Endarteritis
temporal, clinical aspects and therapy, [Löhbers] 139—ab
treatment, intra-arterial procaine or sympathetic block, France, 1163
ARTHRITIS
complicating psoriasis, United Kingdom, 799
in etiology of low back pain, [Diveley & others] *729
in sacroiliac joints, x-ray sign of intestinal lipodystrophy, [Eyler & Doub] *534
tuberculous, prednisone and prednisolone for, United Kingdom, 799
vertebral osteophytosis differentiated from, [Bick] *828
ARTHRITIS, RHEUMATOID
more common in women; diagnosis, United Kingdom, 799
multiple, hormones for, [Marie] 1369—ab
of foot, Finland, 892
treatment, ACTH-cortisone, [Forsbech] 569—ab
treatment, bacterial vaccine and muscle relaxants? 1099
treatment of polyarthritis, cortisone, Switzerland, 229
treatment, physical means, [Rae & Bender] *811
treatment, prednisone and prednisolone, [Hart] 239—ab; [Cohen] 709—ab
treatment, prednisone and prednisolone; peptic ulcer after, [Boland] *813; (reply) [Brick] 1168—C
treatment, salicylamide, (replies) [Salamon] 760—C; [Margolis] 890—C
treatment, succinate-salicylate, [Gilpin] 1261—ab
treatment, zoxazolamine, [Smith & others] *745
ARTHROPLASTY
of hip, skin cap, Finland, 580
ARTHROSIS: See Hip; Knee
ASCARIASIS
treatment, piperazine hydrate, Brazil, 1161
ASCITES
chylous, in childhood, [Whittlesey] 717—ab
cirrhotic, prednisone effect on, France, 1427
ASCORBIC ACID
food standards for (Council report) *1471
importance in diet, (Council report) *1470
vitamin K with, to prevent bleeding after adenotonsillectomy, [Harkins] 1536—ab
ASPERMIA: See Spermatozoa
ASPHYXIA
neonatorum, hyaline membrane in, [Gitlin] 1177—ab
peripheral nerve lesions during coma from, [Olsen] *939
ASPIRATION
endocavitary, for lung abscess, [Monaldi] 1367—ab
ASPIRIN: See Acetylsalicylic Acid
ASSOCIATION: See also American Medical Association; Societies, Medical; list of Societies at end of letter S
investment of funds of, [Norby] *1331
of Life Insurance Medical Directors, mortality study, [Holt & Lee] *736
of Medical Writers and Artists gold medal to Dr. C. Blanco Soler, Spain, 896
ASTHENIA
neurocirculatory, with tachycardia; drugs or exercise for? 726
ASTHMA
complications, treatment, Austria, 1426
in children, [Wright] 213—ab
pleural effusions with, France, 1350
pollen, air filter for? 921
surgical treatment, sympathectomy and bronchoscopy, (reply) [Engelsher] 76—C
treatment, iodine; goiter from, [Turner] 903—ab
treatment of serious cases, [Carryer] 1260—ab
treatment, Prantal in infants, [Bologna] 717—ab
treatment, prednisone, [Capuani] 85—ab; [Feinberg & Feinberg] *264; (Switzerland) 414
treatment radiotherapy of diencephalon, [Jacquelin] 918—ab
unusual cases found in differential diagnosis of, [Howes] 1260—ab
ATABRINE: See Quinacrine
ATAXIA
Locomotor: See Tabes Dorsalis
nicotine adversely affects, United Kingdom, 585
of arm, hand, and foot after brain tumor surgery, rehabilitation for, 1185
ATHEROMA
electron microscopy, United Kingdom, 585; [Lecene] 721—ab
ATHEROSCLEROSIS: See Arteriosclerosis
ATHLETICS: See also Boxing; Golf
use of stethoscope by physical educators advised? 250
ATLAS
rotary subluxation of, torticollis from, [Donaldson] *458
ATOMIC BOMB
civil defense planning and requirements, [Whitney] *1195
defense plans in California, [Warren & Stein] *1215
"Hiroshima Diary," by M. Hachiya, comments on book review, [Hall] 859—C
mobile medical support for civil defense, [Olson & others] *1202; [Howard & others] *1211
transfusion service in bombardment areas, [Crosby] 1168—C
USPHS responsibilities in civil defense, [Hozier] *1206; [Christensen] *1209
ATOMIC ENERGY: See also Radioactive
atomic medicine correspondence course for navy personnel, 129
medical research center to be at Brookhaven, 302
Nuclear Science and Engineering, first issue in Feb., 505
plant workers, leukemia hazard? 151
U. N. publication "Power Reactors," 66
WHO in protection from, 1252
ATOSIL: See Promethazine
ATTIC: See Ear
ATTORNEYS
mutual understanding with physicians, [Medicine and the Law] *1115
AUDIOVISUAL SEMINAR KITS
for postgraduate medical education, [Warner & Bowers] *1206
AUREOMYCIN: See Chlortetracycline
AURICULOTEMPORAL NERVE SYNDROME
gustatory sweating with misdirected regenerated nerve, [Gardner & McCubbin] *272
AUSCULTATION
of chest to diagnose lung cavitation, [Guillaudeu] 1258—C
AUSTRIAN Congress of Physicians discuss chemotherapy, 694
AUTOMOBILES
accident, alleged neglect of fractured ribs after, liability committee studies, Sweden, 413
accident and safety, industrial health congress discusses, 677
accident, pain over gallbladder after, 1185
alcoholic drivers, intoxication more pronounced after antihistamines? 818
A.M.A. Committee on Medical Aspects of Automobile Injuries and Deaths to be enlarged, 1322
epileptic drivers, United Kingdom, 996
parking space factor in building medical unit, [Business Practice] *233
AUTOPSIES
index as comparative standard in medicolegal office evaluation, (replies) [Turkel] 503—C; [Schaefer] 587—C
potential values, guest editorial by Dr. Starr, 1144—E
AVIATION
Civil Aviation Medical Ass'n. convention, Arthur Godfrey to address, 1244
flight after pneumonectomy, how high? 1184
high-speed bail-out, survival, United Kingdom, 898
minimal tuberculosis of lung in Royal Air Force, 898
pathology, meeting of joint committee on, 888
AVIATION, U. S. AIR FORCE
graduates of School of Aviation Medicine, 1527
physician and dentist lieutenants promoted to captains, 576
AZOOSPERMIA: See Spermatozoa

B

BAL: See Dimercaprol
BACITRACIN
bacterial resistance, serial subculture in mixtures effect on, [Molomut & others] *967
BACK
concomitant pain in abdomen [Lewin] 1237—C
low, preemployment examinations, [Diveley & Oglevie] *856
BACKACHE
low; etiology, treatment, [Diveley & others] *729
low, x-ray evaluation, [Landry] 606—ab
lumbar traction for, eliminate factors preventing stretch, (reply) [Judovich] 1258—C
BACTERIA
antibiotic resistance by, serial subculture in mixtures effects on, [Molomut & others] *967
coli, recolonize intestines after preoperative sterilization, [Zettler] 242—ab
in throat flora during chemoprophylaxis of rheumatic fever, [Miller] 1261—ab
research in disease from Israel, 993
transfusion reactions from, [Schostok] 419—ab
vaccines for rheumatoid arthritis? 1099
BACTERICIDES: See also Disinfection
BACTERIUM TYPHOSUM: See Eberthella
BAKERY
cream cakes, poisoning from Chinese eggs, England, 227
BALANTIDIASIS: See Colitis, balantidial
BALARSEN: See Arsthinol
BALLISTOCARDIOGRAM: See Heart
BALLOON
tamponade for bleeding esophageal varices, [Linton & Ellis] *1017
BANDAGE: See Dressings
BANTI'S: See Necrosis
BAR ASSOCIATIONS
physicians liaison, [Medicine and the Law] *1334
BARBITURATES
antagonist, Megimide, [Shaw] 720—ab
chronic abuse, euphomania problem, [Myschetzky] 1178—ab
effect on carbohydrate metabolism, United Kingdom, 585
poisoning, (Denmark) 694; 1162; (United Kingdom) 1351
toxicity; peripheral nerve lesions during coma from, [Olsen] *939
BARTEMEIER, LEO H., and Appel, K. E., guest editorial: Joint Commission on Mental Illness and Health, 392—E
BARTONELLOSIS
Barton (Albertot research award, Peru, 134
BASEDOW'S Disease: See Goiter, Toxic
BASIC SCIENCES
in medical education, Annual Congress discusses, 979
BATHS
public, chlorine poisoning in, United Kingdom, 701
BAYLOR UNIVERSITY
College of Medicine, Taub visiting professorship established, 64
BAYTINAL
ultrashort anesthesia, [Westerborn] 516—ab
BEANS
in peritoneal cavity from vagina, United Kingdom, 1353
BEARSE, CARL, guest editorial: New England Hospital plan for alien women physicians, 562—E
BEHAVIOR
senile, improved with reserpine and Ritalin, [Ferguson & Funderburk] *259
BEHCET SYNDROME
[Zeavin]; (virus of) [Sezer]; (neurologic complications) [Pallis] 1370—ab
BELCHING: See Eructation
BENADON: See Pyridoxine
BENNETT SELF-CYCLING RESPIRATOR by uncuffed tracheostomy tube, [Mörch & others] *864

BENZATHINE PENICILLIN G
free, in rheumatic fever control program, Mich., 569
use in group A streptococci carriers, [Brooks & Moe] *162
BENZEDRINE: See Amphetamine; and Medicolegal Abstracts at end of letter M
BERENS-TOLMAN TONOMETER
Schiötz tonometer compared to, in glaucoma, [Cholst & Horovitz] *661
BER-EX
treatment of arthritis, [Gilpin] 1261—ab
BERMAN POLYETHYLENE PROSTHESIS
after resection for cancer of esophagus, Austria, 1251
BEROLASE: See Cocarboxylase
BETA Radiation: See Radiation
BETEL NUT
chewing in etiology of larynx cancer, [Wynder & others] *1284
BICILLIN: See Benzathine Penicillin G
BILE
drainage through pancreatic duct, relation to pancreatitis [Cross] 337—ab
BILE DUCTS
calculi, postcholecystectomy dyskinesia from, [Walters] *125
roentgen study, Austria, 1161
roentgen study (intravenous), interpreting, [Wise & O'Brien] *819
BILIARY TRACT
disease, noncalculous, surgery in, Peru, 697
inflammation after unrelated surgery fatal, [Levin] *1040; (nonfatal) [Glenn] 1263—ab
obstruction, intrahepatic, from chlorpromazine, [White] 720—ab
reliability of cholecystography, [Wicklson] 336—ab
roentgen study, fatal pancreas necrosis after, [Hershey] 419—ab
surgery, choledochoduodenostomy for postcholecystectomy dyskinesia from pancreatitis, [Walters] *125
surgery for extrahepatic lesions, Brazil, 225
BILIGRAFIN: See Iodipamide
BILIRUBIN IN BLOOD: See Blood bilirubin
BILROTH OPERATIONS
for duodenal ulcer, [Zollinger & Williams] *367
BIOLOGIC WARFARE
civilian defense planning and requirements, [Whitney] *1195
USPHS in civilian defense, [Hozier] *1206; [Christensen] *1209
BIRDS: See Ornithosis; Pigeons
BIRTH: See Infants, Newborn; Labor
BIRTH, premature: See Infants, premature
BIRTH CONTROL: See Contraception
BISMITRIUM: See Hexamethonium
BISMUTH
iodide for amebiasis, United Kingdom, 996
BLADDER
exstrophic, anastomosis to rectum for, Austria, 1348
tuberculous ulcers, monoxychlorosene for, [Lattimer & others] *544
BLANCO SOLER, CARLOS, awarded gold medal by Ass'n. of Medical Writers and Artists, Spain, 896
BLANTON, SMILEY, guest editorial: stuttering, 1472—E
BLASTOMYCOSIS
keloidal, Brazil, 580
BLINDNESS
in physiotherapists, aid for ultraviolet administration, United Kingdom, 898
sun, epidemic, United Kingdom, 1357
BLOOD: See also Medicolegal Abstracts at end of letter M
acid phosphatase elevated in prostate cancer, [Hudson] *811—ab
agammaglobulinemia, antibody deficiency syndrome, [Barandun] 1365—ab
agammaglobulinemia, chest disease with, [Good] 710—ab
agammaglobulinemia, congenital, [Hutchison] 83—ab
agammaglobulinemia, hypoproteinemia differentiated, France, 1530
agammaglobulinemia with susceptibility to respiratory infections, gamma globulin dose for, 920
agammaglobulinemia with thymus tumor, (Diagnostic Problems) [Ramos] *1317; (comment) [Loeb] *1319
Albumin: See Radio-Iodinated Serum Albumin (Human)
alcohol correlated with electroencephalogram after alcohol ingestion, [Holmberg] 81—ab
aminophorase, clinical studies, [Merrill & others] *1454
aminophorase in hepatitis, [Wróblewski & LaDue] *1130
aminophorase to diagnose myocardial infarction, [Kattus & others] *16
antistreptolysin and streptococcal antihyaluronidase in rheumatic fever, [Harris] 1096—ab
Bank: See Blood Transfusion
bilirubin high, constitutional; diagnosis, steroid therapy, [Eanet] 508—ab
bilirubin high, postheptatic, Austria, 312
bilirubin in interpreting intravenous cholangiogram, [Wise & O'Brien] *819
BLOOD—Continued
calcium determination affected by edathamil, [Carr & Frank] 1258—C
calcium, severe infantile hypercalcemia, [Schlesinger] 1434—ab
Cells: See Erythrocytes; Leukocytes
chloride, bedside determination by Scribner method, 421
cholesterol high, atherosclerosis relation, N.S.R., 676
cholesterol high with familial xanthomatosis, Denmark, 412; [Piper] 594—ab
circulation (aortic), interrupt by hibernation and hypothermia, [Parela] 910—ab
circulation, Harvey and research, [Katz] *1137
circulation in pregnancy, radioactive sodium chloride to study, Austria, 1066
circulation occlusion, electrocardiogram during, [Hicks] 1262—ab
circulation (uterine) estimation in pregnancy at term, [Metcalfe] 81—ab
Coagulation, Anticoagulants: See Anticoagulants
Dyscrasias: See also specific dyscrasias as Agranulocytosis
dyscrasias from chlorpromazine, (Council report) 287
egg media compared for isolating Mycobacterium tuberculosis, [Dunlop] 695—ab
Eosinophils Circulating in: See Eosinophils
Fibrinogen: See Fibrinogen
formation, radiation hazards to nonradiologists, [Ritto & others] *1
galactosemia in infant, milk-free diet for; give lactose in diet? 341
Globulin: See Globulin
group incompatibility not cause of neonatal hepatitis, [Krainin & Lapan] *937
groups, O, A, B, and AB, distribution among ethnic groups, Israel, 994
histamine with eosinophilia, India, 893
histaminolytic activity, ovary hormones effect on, [Quaini] 1369—ab
isoniazid in cerebrospinal fluid and, relation after oral use, [Malmoti] 238—ab
lead, edathamil calcium-disodium effect on, in battery workers, [Manville] 86—ab
loss effect on water, electrolyte and nitrogen metabolism, [Flear] 419—ab
penicillin after oral G and V types, (food intake relation) [Jones] 85—ab; [Martin & others] *928; (in subacute bacterial endocarditis) [Quinn & others] *931
penicillin and streptomycin after simultaneous administration, [Hassing] 509—ab
Plasma: See Plasma
potassium high, and aldosteronuria, Switzerland, 1165
pressure: See laboratory tests, changes in, 152
Proteins: See also Blood agammaglobulinemia; **C-Reactive Protein**; **Globulin**; **Radio-Iodinated Serum Albumin**
proteins, hypoproteinemia differentiated from agammaglobulinemia, France, 1530
proteins, hypoproteinemia improves after malaria for nephrotic syndrome, [Gilbertsen & Rashour] *25
proteins, proteinemia with hyperaminoaciduria in children, France, 1530
prothrombin determination at home, (replies) [Manchester; Bruce] 342
sodium, dilutional hyponatremic shock in transurethral prostatectomy, [Harrison] 1438—ab
sodium test for adrenocortical insufficiency, [Perlmutter] *117
sugar; aglycemia ever occur? 1538
sugar high in obese diabetic woman, 63; high insulin dosage harmful? 248
sugar, hypoglycemia; cell ratio in Islands of Langerhans in surgery for, [Leger] 88—ab
sugar, hypoglycemia in hyperinsulinism, [Breidahl & others] *198
sugar, hypoglycemia (postinfusion), 876—E
sugar, hypoglycemic oral sulfonamides, (France) 1083; (carbutamide) [Ribolfo & Kelley & others] 1320—E
sugar, sarpankh juice effect on, India, 696
Tests: See also Cancer serodiagnosis; Syphilis serodiagnosis
tests for coccidioidomycosis, [Smith & others] *546
tests for disseminated lupus erythematosus, [Fallet] 720—ab; [Basset-Lactonique] 721—ab
Transaminase: See Blood aminophorase
Types: See Blood groups
urea clearance after intravenous use, [David & Settlage] *943
volume, Cr^{51}-labeled erythrocytes to determine, [Meyer] *1312
volume in hypertension and heart failure, Cr^{51}-labeled erythrocytes to measure, [Warner & others] *578
volume studies, Finland, 580
BLOOD PRESSURE
auricular, cardiac irregularities effects on, during thoracotomy, [Wilson] 1263—ab
cuff to measure, in test for lung congestion using Valsalva maneuver, [Knowles & others] *44
effect of work on, France, 695
BLOOD PRESSURE—Continued
low; causes, treatment, 1183
low, during surgery, hydrocortisone for, [Howland & others] *1271
low (induced) for eclampsia, [Cosnutta] 82—ab
BLOOD PRESSURE, HIGH
arterial, double aspect, [Zarday] 238—ab
arterial, symptom, not a disease, France, 1349
body fluids in, [Walser & others] *858
complicating nephrotic syndrome, malaria for, [Gilbertsen & Rashour] *25
complications, cardiovascular disease, [Smithwick & others] *1023
complications, cardiovascular disease, Smithwick's sympathectomy vs. medical therapy, [White] *1027
complications, cardiovascular-renal, lung consolidation as sign, [Howes] 1260—ab
essential, 673—E
etiology: renal artery occlusion, [Poutasse] 1435—ab
in 3 generations, United Kingdom, 1256
liver cirrhosis relationship, [Loyke] 237—ab
malignant, ganglion-block for, pulmonary edema and fibtosis during, [Viersma] 903—ab
malignant, transplant kidney between identical twins, [Merrill & others] *277
Portal Hypertension: See Portal Vein
pulmonary: ventricular septal defects with, pump-oxygenator for surgery, [DuShane & others] *950
severe in Conn's syndrome [Chalmers] 1433—ab
treatment, current, [Coan] 593—ab
treatment, ganglion blocking, [Bauer] 418—ab
treatment, Hunteria elurnea pichon and Morinda citrifolia, France, 133; (Morinda) [Dang Van Ho] 146—ab
treatment, methium plus reserpine, [Crawley] 705—ab
treatment, protoveratrines A and B, [Guzzi] 719—ab
treatment, Rauwolfia effects in, [Lewis & others] *622
treatment, Rauwolfia: mental depression from, France, 581
treatment, variables in evaluating drugs, [Shapiro] *530
treatment, veratrum and Rauwolfia, [Voskian] 999—ab
unilateral renal, nephrectomy cures, [Kobayashi] 810—ab
vascular obstruction in pyelonephritis relation to, [Kincaid-Smith] 812—ab
BLOOD TRANSFUSION
blood bank in Bergen community, N. J., 784
complications, bacterial; etiology, [Schoutek] 419—ab
complications, viral hepatitis; abnormal liver tests in carriers, [Norris & others] *1110
effect on water, electrolyte and nitrogen metabolism after trauma, [Flear] 419—ab
exchange, for icterus gravis neonatorum, [Betke] 1369—ab
extravagant use in hospitals, United Kingdom, 501
for hemophilia, [Brinkhous] 908—ab
in atomic bombardment areas, [Crosby] 1168—C
in civil defense planning and requirements, [Whitney] *1195
Joint Blood Council encouraged by President Eisenhower; make new plans, 981
Landsteiner award in blood banking, 63
National Blood Transfusion Service report, United Kingdom, 780
postcoronary blood donors safe? 1268
program inaugurated at Ohio State U., 685
reactions, injectable antihistaminics for, N.N.R., 777
with erythrocytes, Austria, 1251
BLOOD VESSELS
degeneration in diabetes related to lipid metabolism, Switzerland, 1165
disease in idiopathic cardiac hypertrophy, [DeMuth] 83—ab
peripheral disease, blood aminophorase in, [Merrill & others] *1454
roentgen study, serial vs. cerebral angiography, Switzerland, 1165
roentgen study to diagnose subdural hematoma, Brazil, 312
roentgen study to evaluate intracranial trauma, [Lofstrom] 918—ab
woven synthetic prostheses appraised, [Determ] 807—ab
BLUE SHIELD
Commission, A.M.A. representative on, 1322
BODY
build in diabetes, England, 227
Fluids: See Fluids, body
Growth: See Growth
Increase in children's size, United Kingdom, 702
Weight: See also Obesity
weight loss in healthy subject from Meclizine hydrochloride; how much loss is pathological? 423
BONAMINE HYDROCHLORIDE: See Meclizine Hydrochloride

BONDS
doctor and municipal bonds, (Business Practice) [Burgert] *136; (reply) [Walker & Robinson] 800—C
BONE MARROW
changes in tumor presence, [Korinth] 245—ab
depression from nitrogen mustard and TEM, (reply) [Franco] 415—C
intraossal phlebography, Austria, 132
sternal aspiration, cardiac tamponade after, [Jenkins] 326—ab
BONES
fractures in face: face, neck, and thoracic emphysema from, [Heslop] 240—ab
grafts, Phemister's subperiosteal or intracortical, for pseudoarthrosis, [Ritter] 142—ab
osteolysis (massive) relation to hemangiomatosis, [Gorham] 598—ab
osteosynthesis, history, Brazil, 1427
pain severe in multiple myeloma, treatment, 1374
radium deposition in, [Looney & Colodzin] *1
radium internally produces lesions in, [Marshak & others] *41
roentgen study after using high-fluoride water, [Leone] 148—ab
Tuberculosis: See also Arthritis, tuberculous
tuberculosis (fistulating) with mixed infection, tetracycline for, [Behrendt] 79—ab
tuberculosis, streptomycin for, [Dougherty] 597—ab
tuberculosis treatment, [Campos] 596—ab; [Smith] 597—ab
tumors, benign conditions simulating, [Collins & Collins] *431
BOOKS: See also Book Reviews at end of letter B
"Doctor at Large" by R. Gordon reviewed, England, 314
for Korean medical schools, shipping instructions, 572
Harvey's book on circulation presented to John Crerar Library by American Heart Ass'n., [Katz] *1137
"Healthful School Living," Joint Committee on Health Problems in Education to prepare, 1323
"Hiroshima Diary," by M. Hachiya, comments on book review, [Hall] 899—C
personal health log, guest editorial by Dr. Dragstedt, 1320—E
"Why Patients See Doctors" by Standish and others, A.M.A. summary, (Bureau article) [Dickinson] *213
BORTRIOXYBENZOIC ACID
ester for onychomycosis, Switzerland, 995
BOSTON UNIVERSITY SCHOOL OF LAW
senior and graduate course on medicolegal aspects of personal injury, 489
BOTHWELL (James Hepburn), 4th EARL
glass-topped coffin for body, United Kingdom, 898
BOXING
injuries, especially to brain, United Kingdom, 798
BRACHIAL PLEXUS
compression can cause hand numbness, (reply) [Ehni] 922
BRADYCARDIA
induced by reserpine, [Schumann; Halprin] 705—ab
sinus, molar sodium lactate for, [Bellet & others] *1293
BRAIN
boxing injuries, United Kingdom, 798
cerebrovascular accident, prednisone reaction simulates, [Schroeder & Sherman] 1354—C
complications of hypertension, Morinda citrifolia for, [Dang Van Ho] 146—ab
diseases, zoxazolamine for, [Amols] *742; [Abrahamsen & Baird] *749; [Rodriguez-Gomez & others] *752
electroencephalogram correlated with blood alcohol after standardized alcohol dose, [Holmberg] 81—ab
electroencephalogram in phenylpyruvic oligophrenia, [Fois] 914—ab
electroencephalography's role, guest editorial by Dr. Bucy, 1232—E
Hemorrhage: See also Meninges; and "Cerebral Hemorrhage" under Medicolegal Abstracts at end of letter M
hemorrhage, apoplexy: sympathetic block for, [de Takats] 80—ab
hemorrhage, postapoplectic disturbance of deglutition, Austria, 794
hypothermia effect on experimental occlusion of afferent circulation, [McMurrey] 1097—ab
International Symposium on Diencephalon, May, Italy, 1245
metabolism, acetazolamide effect on, in epilepsy, [Lombroso & others] *268
metabolism after steroid anesthesia, [Gordan] 1002—ab
radiotherapy of diencephalon in asthma, [Jacquelin] 918—ab
roentgen study, serial vs. cerebral angiography, Switzerland, 1165
softening of stem and basilar thrombosis after neck manipulation, [Ford] 1264—ab
BRAIN—Continued
surgery for epilepsy, [Titrud] 242—ab; [Weber] 420—ab
surgery, hemispherectomy for hemiplegia and encephalopathies, [Ferey] 1535—ab
surgery, leukotomy (2nd), rostral type after 5 years; rostral and prefrontal compared, [Pippard] 599—ab
surgery, lobotomy (prefrontal) for intractable ulcerative colitis, [Levy & others] *1277
surgery, trephination in traumatic subdural hematoma, Switzerland, 1165
surgery, urea to reduce intracranial pressure proposed, [Javid & Settlage] *943
tumor operation, rehabilitation for ataxia of arm, hand, and foot after, 1185
tumors, glioma, x-ray for, [Campi] 1368—ab
tumors, infiltrating ependymoma, India, 893
tumors, parasagittal meningioma, [Hoessly] 808—ab
tumors, parietal, without signs of, Peru, 895
tumors, radioactive isotopes and surgery for, Austria, 1086
BREAST
actinomycosis of, India, 74
cancer and trauma, 342
cancer diagnosis, value of yearly examination, [Rutherford & Banks] *1289
cancer in women and men, India, 1163
cancer incidence and mortality increasing, Italy, 697
cancer (inoperable), survival in, Brazil, 992
cancer (metastatic), adrenalectomy in, [Hughes-Jones] 327—ab
cancer (metastatic), endocrines for, [Pearson] 324—ab
cancer (metastatic), hormones vs. x-ray for, (reply) [Garland] 586—C
cancer (occult), [Dujovich] 1179—ab
cancer, oophorectomy and adrenalectomy for, [Bastos] 912—ab; [Cuningham] 1174—ab
cancer, parasternal lymph nodes in spread and prognosis, [Kaiser] 141—ab
cancer, preoperatively irradiated, microscopy in, [Grill] 1180—ab
cancer (primary), 2: prognosis; sterilize for? Chance of occurring in twin, 1374
cancer, spinothalamic section for pain of, [French] 910—ab
feeding and infection, United Kingdom, 898
hypoplasia, plastic correction, Austria, 1426
mass in young man, microscopic analysis for, 727
puerperal mastitis, acute, [Gunther] 1434—ab
puerperal mastitis (endemic micrococcic), effect on the newborn, [Ferrario] 1369—ab
puerperal mastitis, x-ray for, [Rossi] 514—ab
Surgery: See also Breast cancer
surgery, mastectomy, lymphedema after: hyaluronidase by iontophoresis for, (reply) [Funk] 90
tuberculosis, isoniazid cured, Austria, 795
tumors, paraffinoma, [Tinckler] 511—ab
BREATH; Breathing: See Respiration
BRITISH
Dental Ass'n. denies that dentifrices will prevent decay, 315; 702
Health Service: See National Health Service
Medical Ass'n., (to study homosexuality) 699; (exchange visits with A.M.A.) 1352; (examines physician anonymity on the air) 1531
Medical Journal criticizes Ministry of Health on poliomyelitis vaccination, 996
Society of Gastroenterologists meeting, 313
BROMSULPHALEIN: See Sulfobromophthalein Sodium
BRONCHIECTASIS
in infants, surgery for, [Pignero] 711—ab
BRONCHITIS
asthmatic, in infants: treatment, [Bologna] 717—ab
chronic, prognosis; insurance mortality study, [Bolt & Lew] *736
incidence, United Kingdom, 799
lung cancer relation, England, 314
BRONCHOGRAPHY: See Bronchus, roentgen study
BRONCHOLITHIASIS: See Bronchus calculi
BRONCHOPNEUMONIA
complicating fibrocystic pancreas, Austria, 1348
in infants, tetracyline for, Austria, 1426
BRONCHOSCOPY
indications for, in asthma, (reply) [Engelsher] 76—C
BRONCHUS
blockade test of pulmonary function, Austria, 1426
calculi: broncholithiasis, [Groves] 807—ab
calculi: broncholithiasis as cause of bronchoesophageal fistula, [Davis & others] *555
cancer, 5 year survey, [McKay] 336—ab
cancer, industrial aspects, [Breslow] 1096—ab
cancer, radiotherapy evaluated, England, 73
cancer, radiotherapy with resection for, [Bromley] 140—ab
cancer, surgical treatment, (Austria) 132; (survival, United Kingdom) 699
cancer, x-ray palliation, [Blanshard] 246—ab
BRONCHUS—Continued
dilators for pulmonary emphysema appraised, [Leslie & others] *1125
roentgen study, dangers in tuberculosis, [Perry] 246—ab
roentgen study in tuberculosis, France, 1089
roentgen study, lipiodol injected into trachea safe? 88
stenosis, incidence with pulmonary tuberculosis, Finland, 580
BRUCELLOSIS
complications, sciatica, India, 993
in cows, milk sanitation code amended, N. Y., 123
BRYANT'S TRACTION
modified, in children with fractured femurs, [Stryker] *388
BUCY, PAUL C., guest editorial: electroencephalography's role, 1232—E
BURNS
alkali, of esophagus, management, [Carver & others] *1447
Döhle bodies in leukocytes after, [Weiner] 605—ab
electric, death 63 days later, after skin transplants, Austria, 132
experimental, exposure vs. occlusive dressings in, [Holman] 913—ab
rectal, from decomposed paraldehyde, [Agranat] 332—ab
statistics on 2,418 cases, Brazil, 72
BURSITIS
subacromial or subdeltoid, Brazil, 313
BUSINESS PRACTICE
building a medical unit, Sears Roebuck Foundation guide, (physical factors) *233; (size) *319; (building) *504; (services) *589; (medical facilities) *900; (room arrangements) *1356
doctor and municipal bonds, [Burgert] *136; (reply) [Walker & Robinson] 800—C
your investments while you are in Europe, [Mitchell] *78
BUSULFAN
cataracts produced in rats by, [Solomon] 604—ab
effect on nucleic acid in leukemic elements, [Gavosto] 812—ab
treatment status in leukemias, (Council report) *1228
BUTAPYRIN: See Phenylbutazone
BUTAZOLIDIN: See Phenylbutazone
BUTTER
can it be made from sour cream? 342
BYSSINOSIS: See Pneumoconiosis

BOOK REVIEWS

Abdomen
Surgical Technic of Abdominal Operations, [Spivack] 1537
Adolescence
Growth at Adolescence, [Tanner] 919
Allergy Cooking, [Conrad] 150
Amebiasis
Problems in Amoebiasis, [Rees] 422
American Foundation, Medical Research: Mid-century Survey, 814
American Foundations and Their Fields, [Rich] 1003
Analgesics
Clinical Analgetics, [Gross & Schiffrin] 815
Anatomy
Shearer's Manual of Human Dissection, [Tobin] 247
Stereoscopic Atlas of Human Anatomy: Upper Extremity, [Bassett] 1373
Anesthesia
Hypothermic Anesthesia, [Virtue] 815
Obstetrical Anesthesia, [Hershenson] 338
Anthropology
Research Films in Biology, Anthropology, Psychology, and Medicine, [Michaelis] 725
Antimetabolites and Cancer, [Rhoads] 919
Arms
Stereoscopic Atlas of Human Anatomy, [Bassett] 1373
Army, United States
Medical Department, United States Army, Surgery in World War II: Vascular Surgery, [Elkin & De Bakey] 1181
Medical Department, United States Army: Preventive Medicine in World War II, [Coates & others] 150; 1372
Arteries: See Blood Vessels
Atlas
Atlas of Bronchial Lesions in Pulmonary Tuberculosis, [Dijkstra] 1181
Atlas of Clinical Pathology of the Oral Mucous Membranes, [Orban & Wentz] 150
Atlas of General Surgery, [Wilder] 1181
Atlas of Rush Pin Technics, [Rush] 607
Grundriss und Atlas der gynäkologischen Cytodiagnostik, [Smolka & Soost] 1372
Stereoscopic Atlas of Human Anatomy: Upper Extremity, [Bassett] 1373
Audiology: See Hearing
Aviation
Medical Support of the Army Air Forces in World War II, [Link & Coleman] 247
Bacteriology
Topley and Wilson's Principles of Bacteriology and Immunity in Two Volumes, [Wilson & Miles] 1437

Bakay, L., Blood-Brain Barrier, with Special Regard to Use of Radioactive Isotopes. 1373
Barborka, C. J., and Texter, E. C., Jr., Peptic Ulcer. 725
Barnett, A. J., and Fraser, J. R. E., Peripheral Vascular Disease. 1182
Bassett, D. L., Stereoscopic Atlas of Human Anatomy: Upper Extremity. 1373
Bateman, J. E., Shoulder and Environs. 1181
Beck, A. C., and Rosenthal, A. H., Obstetrical Practice. 1098
Becker, N., editor, Financing Hospital Care in the United States. Volume 3. 87
Berman, R., Obstetrics & Gynecology: Series of Monographs, Obstetrical Roentgenology. 422
Biochemistry
Biochemistry and Central Nervous System. [McIlwain] 1267
Dynamic Equilibrium of Body Proteins. [Whipple] 1437
Biology
Research Films in Biology, Anthropology, Psychology, and Medicine. [Michaelis] 725
Blood-Brain Barrier, with Special Regard to Use of Radioactive Isotopes. [Bakay] 1373
Blood Pressure
High Blood Pressure. [Pickering] 87
Blood Vessels
Medical Department, United States Army, Surgery in World War II: Vascular Surgery. [Elkin & DeBakey] 1181
New Concepts in Surgery of the Vascular System. [Holman] 517
Peripheral Vascular Disease. [Barnett & Fraser] 1182
Body Fluids, [Elkinton & Danowski] 247
Bowes, K., editor, Modern Trends in Obstetrics and Gynaecology. 814
Brain, Sir Russell, and Strauss, E. B., Recent Advances in Neurology and Neuropsychiatry. 1182
Brain: See also Neurology
Blood-Brain Barrier, with Special Regard to Use of Radioactive Isotopes. [Bakay] 1373
Brain Mechanisms in Diachrome. [Krieg] 723
Personality Changes Following Frontal Leucotomy. [Tow] 607
Bronchus
Atlas of Bronchial Lesions in Pulmonary Tuberculosis. [Dijkstra] 1181
Burling, T., Lentz, E. M., and Wilson, R. N., Give and Take in Hospitals: Study of Human Organization in Hospitals. 1372
Burns
Mechanisms of Healing in Human Wounds. [Hartwell] 338; (correction) 688
Cancer
Antimetabolites and Cancer. [Rhoads] 919
Cancer and Common Sense. [Cribb] 1003
Cardiovascular System: See also Heart
Cardiac Diagnosis. [Rushmer] 1267
Clinical Roentgenology. [de Lorimier & others] 87
Henry Ford Hospital International Symposium on Cardiovascular Surgery. [Lam] 607
Chest X-Ray Diagnosis, [Ritvo] 814
Children: See also Infants; Pediatrics
Education of Mentally Handicapped Children. [Wallin] 723
Feeding Your Baby and Child. [Spock] 1003
Ciba Foundation Symposium on Experimental Tuberculosis: Bacillus and Host. With Addendum on Leprosy. [Wolstenholme & Cameron] 1003
Coates, J. B., Jr., Hoff, E. C., and others, editors, Preventive Medicine in World War II. 150; 1372
Cole, W. H., editor, Operative Technic in General Surgery. 815
Commission on Financing of Hospital Care
Financing Hospital Care in the United States. Volume 3. [Becker] 87
Community
Health, Culture and Community: Case Studies of Public Reactions to Health Programs. [Paul] 1267
Conrad, M. L., Allergy Cooking. 150
Cookery
Allergy Cooking. [Conrad] 150
Cornea. [Thomas] 724
Cornell Conference on Therapy. Volume Seven. [Gold] 422
Council for International Organizations of Medical Sciences. Glaucoma. [Duke-Elder] 1181
Cribb, G., Jr., Cancer and Common Sense. 1003
Culture
Health, Culture and Community: Case Studies of Public Reactions to Health Programs. [Paul] 1267
Curtis, G., and others, Is Your Halo on Straight? 607
Cytology
Grundriss und Atlas der gynäkologischen Cytodiagnostik. [Smolka & Soost] 1372
Dack, G. M., Food Poisoning. 1373
Dalldorf, G., Introduction to Virology. 150
de Lorimier, A. A., Moehring, H. G., and Hannan, J. R., Clinical Roentgenology. Volume III: Lungs and Cardiovascular System. 87
Dentistry
Atlas of Clinical Pathology of the Oral Mucous Membrane. [Orban & Wentz] 150
Diabetes Mellitus
Clinical Care of the Diabetic. [Short] 422
Diachrome
Brain Mechanisms in Diachrome. [Krieg] 723
Diagnosis
Cardiac Diagnosis. [Rushmer] 1267
Chest X-Ray Diagnosis. [Ritvo] 814
Grundriss und Atlas der gynäkologischen Cytodiagnostik. [Smolka & Soost] 1372
DiCarlo, L. M., Amster, W. W., and Herer, G. R., Speech after Laryngectomy. 919
Diet
Modern Nutrition in Health and Disease. [Wohl & Goodhart] 1267
Dijkstra, C., Atlas of Bronchial Lesions in Pulmonary Tuberculosis. 1181
Disease
Medical and Psychological Teamwork in the Care of the Chronically Ill. [Harrower] 815
Planning New Institutional Facilities for Long-Term Care. [Nicholson] 1437
Dispensatory of the United States of America. [Osol & Farrar] 723
Drugs: See Pharmacology
Duke-Elder, Sir Stewart, editor, Glaucoma. 1181
Dynamic Equilibrium of Body Proteins. [Whipple] 1437
Education
Education of Mentally Handicapped Children. [Wallin] 723
Pediatric Years. [Spekter] 517
Eichholtz, F., Lehrbuch der Pharmakologie im Rahmen einer allgemeinen Krankheitslehre für praktische Ärzte und Studierende. 1437
Elkin, D. C., and DeBakey, M. E., editors, Medical Department, United States Army, Surgery in World War II: Vascular Surgery. 1181
Elkinton, J. R., and Danowski, T. S., Body Fluids. 247
Embolism
Thrombosis and Embolism. [Koller & Merz] 607
Encyclopedia
Surgical Technic of Abdominal Operations. [Spivack] 1537
Endocarditis
Subacute Bacterial Endocarditis. [Kerr] 1182
Endocrinology
Vitamins and Hormones. Volume XIII. [Harris & others] 338
Ethics, Medical
Is Your Halo on Straight? [Curtis] 607
Extremities
Peripheral Vascular Disease. [Barnett & Fraser] 1182
Faith Is the Answer: A Pastor and a Psychiatrist Discuss Your Problems. [Peale & Blanton] 1537
Feeding Your Baby and Child. [Spock] 1003
Ferguson, L. K., and Kaplan, L., Surgery of the Ambulatory Patient. 422
Fey, B., and others, editors, Traité de technique chirurgicale, (by Oberlin and others) 814
Financing Hospital Care in the United States. Volume 3: Financing Hospital Care for Nonwage and Low-Income Groups. [Becker] 87
Fluids
Body Fluids. [Elkinton & Danowski] 247
Food Poisoning. [Dack] 1373
Foundations
American Foundations and Their Fields. [Rich] 1003
Fractures
Atlas of Rush Pin Technics. [Rush] 607
Functional Otology. [Heller & others] 724
Give and Take in Hospitals: Study of Human Organization in Hospitals. [Burling & others] 1372
Glaucoma. [Duke-Elder] 1181
Gold, H., editor, Cornell Conferences on Therapy. Volume Seven. 422
Gross, E. G., and Schiffrin, M. J., Clinical Analgetics. 815
Growth at Adolescence. [Tanner] 919
Gynecology
Grundriss und Atlas der gynäkologischen Cytodiagnostik. [Smolka & Soost] 1372
Modern Trends in Obstetrics and Gynaecology. [Bowes] 814
Obstetrics & Gynecology: Series of Monographs, Obstetrical Roentgenology. [Berman] 422
Handbook of Hospital Psychiatry. [Linn] 1537
Harris, R. S., Marrian, G. F., and Thimann, K. V., editors, Vitamins and Hormones. Volume XIII. 338
Harrower, M., editor, Medical and Psychological Teamwork in the Care of the Chronically Ill. 815
Hartwell, S. W., Mechanisms of Healing in Human Wounds. 338; (correction) 688
Health
Health, Culture and Community: Case Studies of Public Reactions to Health Programs. [Paul] 1267
Medical Department, United States Army: Preventive Medicine in World War II: Personal Health Measures and Immunization. [Coates & others] 1372
Health—Continued
Pediatric Years: Guide in Pediatrics for Workers in Health, Education and Welfare. [Spekter] 517
Hearing
Functional Otology: Practice of Audiology. [Heller & others] 724
Heart: See also Cardiovascular System
Interpretation of the Unipolar Electrocardiogram. [Myers] 1437
Heaton, C. E., editor, Obstetrics & Gynecology. 422
Heemskerk, Th. R., translator, Atlas of Bronchial Lesions in Pulmonary Tuberculosis. (by Dijkstra) 1181
Heller, M. F., Anderman, B. M., and Sieger, E.E., Functional Otology. 724
Henry Ford Hospital International Symposium on Cardiovascular Surgery. [Lam] 607
Hershenson, B. B., Obstetrical Anesthesia. 338
Holman, E., New Concepts in Surgery of the Vascular System. 517
Hormones
Vitamins and Hormones, Volume XIII. [Harris & others] 338
Hospitals
Financing Hospital Care in the United States. Volume 3. [Becker] 87
Give and Take in Hospitals: Study of Human Organization in Hospitals. [Burling & others] 1372
Handbook of Hospital Psychiatry. [Linn] 1537
Henry Ford Hospital International Symposium on Cardiovascular Surgery. [Lam] 607
Planning New Institutional Facilities for Long-Term Care. [Nicholson] 1437
Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943: [Lamb] 815
Hunter, D., Diseases of Occupations. 1098
Hygiene: See also Health
Preventive Medicine in World War II. Volume II. Environmental Hygiene. [Coates & Hoff] 150
Hypothermic Anesthesia. [Virtue] 815
Immunology
Medical Department, United States Army: Preventive Medicine in World War II: Personal Health Measures and Immunization. [Coates & others] 1372
Topley and Wilson's Principles of Bacteriology and Immunity in Two Volumes. [Wilson & Miles] 1437
Industrial Diseases
Diseases of Occupations. [Hunter] 1098
Infants: See also Children; Pediatrics
Feeding Your Baby and Child. [Spock] 1003
Interpretation of the Unipolar Electrocardiogram. [Myers] 1437
Is Your Halo on Straight? [Curtis] 607
Johnson, W., editor, Stuttering in Children and Adults. 1537
Karsner, H. T., Human Pathology. 1098
Kerr, A., Jr., Subacute Bacterial Endocarditis. 1182
Koller, Th., and Merz, W. R., editors, Thrombosis and Embolism. 607
Krieg, W. J. S., Brain Mechanisms in Diachrome. 723
Lactimal System. [Veirs] 87
Lam, C. R., editor, Henry Ford Hospital International Symposium on Cardiovascular Surgery. 607
Lamb, A. R., Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868—1943. 815
Larynx
Speech after Laryngectomy. [Di Carlo & others] 919
Leprosy
Ciba Foundation Symposium on Experimental Tuberculosis: Bacillus and Host. With an Addendum on Leprosy. [Wolstenholme & Cameron] 1003
Lesnik, M. J., and Anderson, B. E., Nursing Practice and the Law. 724
Link, M. M., and Coleman, H. A., Medical Support of the Army Air Forces in World War II. 247
Linn, L., Handbook of Hospital Psychiatry. 1537
Lodge, T., Recent Advances in Radiology. 247
Lungs
Clinical Roentgenology. [de Lorimier & others] 87
McGregor, A. L., Surgery of the Sympathetic. 422
McIlwain, H., Biochemistry and Central Nervous System. 1267
Malaria
Man's Mastery of Malaria. [Russell] 723
Mechanisms of Healing in Human Wounds. [Hartwell] 338; (correction) 688
Medical and Psychological Teamwork in the Care of the Chronically Ill. [Harrower] 815
Medical Centers
Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943. [Lamb] 815
Medical Department, United States Army, (Surgery in World War II: [Elkin & De Bakey] 1181; (Preventive Medicine in World War II: [Coates & others] 150; 1372

Medical Jurisprudence
Nursing Practice and the Law. [Lesnik & Anderson] 724
Medical Research: Midcentury Survey. [American Foundation] 814
Medical Support of the Army Air Forces in World War II. [Link & Coleman] 247
Medically Indigent
Financing Hospital Care in the United States. Volume 3: Financing Hospital Care for Nonwage and Low-Income Groups. [Becker] 87
Medicine
Complete Medical Guide. [Miller] 1373
Research Films in Biology, Anthropology, Psychology, and Medicine. [Michaelis] 725
Mental Deficiency
Education of Mentally Handicapped Children. [Wallin] 723
Metabolism
Antimetabolites and Cancer. [Rhoads] 919
Michaelis, A. R., Research Films in Biology, Anthropology, Psychology, and Medicine, 725
Military Medicine: See World War II
Miller, R. F., Complete Medical Guide, 1373
Modell, W., Relief of Symptoms, 150
Mouth
Atlas of Clinical Pathology of the Oral Mucous Membrane. [Orban & Wentz] 150
Mycology
Therapy of Fungus Diseases: International Symposium. [Sternberg & Newcomer] 724
Myers, G. B., Interpretation of the Unipolar Electrocardiogram, 1437
Nash, D. F. E., Principles and Practice of Surgical Nursing, 247
Neurology: See also Brain
Biochemistry and Central Nervous System. [McIlwain] 1267
Progress in Neurology and Psychiatry, Volume X. [Spiegel] 338
Recent Advances in Neurology and Neuropsychiatry. [Brain & Strauss] 1182
Surgery of the Sympathetic. [McGregor] 422
Neuropsychiatry
Recent Advances in Neurology and Neuropsychiatry. [Brain & Strauss] 1182
Nicholson, C. E., Planning New Institutional Facilities for Long-Term Care, 1437
Nurses and Nursing
Nursing Practice and the Law. [Lesnik & Anderson] 724
Principles and Practice of Surgical Nursing. [Nash] 247
Nutrition
Modern Nutrition in Health and Disease. [Wohl & Goodhart] 1267
Oberlin, S., Quinn, J., and Perratia, J., Traité de technique chirurgicale, 814
Obesity
How to Reduce Surely and Safely. [Pollack & Morse] 725
Obstetrics
Modern Trends in Obstetrics and Gynaecology (Second Series). [Bowes] 814
Obstetrical Anesthesia. [Hershenson] 338
Obstetrical Practice. [Beck & Rosenthal] 1698
Obstetrics & Gynecology: Series of Monographs. Obstetrical Roentgenology. [Berman] 422
Office Procedures. [Williamson] 919
OPHTHALMOLOGY
Cornea. [Thomas] 724
Glaucoma. [Duke-Elder] 1181
Ophthalmology: Textbook for Diploma Students. [Trevor-Roper] 725
Orban, B. J., Wentz, F. M., and others, Atlas of Clinical Pathology of Oral Mucous Membrane, 150
Orthopedics
Shoulder and Environs. [Bateman] 1181
Osol, A., and Farrar, G. E., Jr., Dispensatory of the United States of America, 721
Pathology
Atlas of Clinical Pathology of Oral Mucous Membrane. [Orban & others] 150
Human Pathology. [Karsner] 1098
Paul, B. D., editor, Health, Culture and Community: Case Studies of Public Reactions to Health Programs, 1267
Peale, N. V., and Blanton, S., Faith is the Answer, 1537
Pediatrics: See also Children; Infants
Pediatric Years: Guide in Pediatrics for Workers in Health, Education and Welfare. [Spekter] 517
Survey of Clinical Pediatrics. [Slobody] 1098
Peptic Ulcer: Diagnosis and Treatment. [Barborka & Texter] 725
Peripheral Vascular Disease. [Barnett & Fraser] 1182
Personality Changes Following Frontal Leucotomy. [Tow] 607
Pharmacology
Lehrbuch der Pharmakologie im Rahmen einer allgemeinen Krankheitslehre für praktische Ärzte und Studierende. [Eichholtz] 1437
Photography
Research Films in Biology, Anthropology, Psychology, and Medicine. [Michaelis] 725
Physicians
Office Procedures. [Williamson] 919
Pickering, G. W., High Blood Pressure, 97
Planning New Institutional Facilities for Long-Term Care. [Nicholson] 1437
Poisoning: See Toxicology
Pollack, H., and Morse, A. D., How to Reduce Surely and Safely, 725
Presbyterian Hospital and Columbia-Presbyterian Medical Center, 1868-1943. [Lamb] 815
Preventive Medicine in World War II. [Coates & others] 150: 1372
Proteins
Dynamic Equilibrium of Body Proteins. [Whipple] 1437
Psychiatry
Faith in the Answer: A Pastor and a Psychiatrist Discuss Your Problems. [Peale & Blanton] 1537
Handbook of Hospital Psychiatry. [Linn] 1537
Progress in Neurology and Psychiatry, Volume X. [Spiegel] 338
Psychology
Medical and Psychological Teamwork in Care of the Chronically Ill. [Harrower] 815
Research Films in Biology, Anthropology, Psychology, and Medicine. [Michaelis] 725
Radioactivity
Blood-Brain Barrier, with Special Regard to the Use of Radioactive Isotopes. [Bakay] 1373
Radiology: See also Roentgenology
Recent Advances in Radiology. [Lodge] 247
Recipes: See Cookery
Rees, J., Amebiasis in Amebiasis, 422
Relief of Symptoms. [Modell] 150
Religion
Faith in the Answer: A Pastor and a Psychiatrist Discuss Your Problems. [Peale & Blanton] 1537
Research
Medical Research: Midcentury Survey. [American Foundation] 814
Research Films in Biology, Anthropology, Psychology, and Medicine. [Michaelis] 725
Respiration
Speech after Laryngectomy. [DiCarlo & others] 919
Rhoads, C. P., editor, Antimetabolites and Cancer, 919
Rich, W. S., American Foundations and Their Fields, 1002
Ritvo, M., Chest X-Ray Diagnosis, 814
Roentgenology: See also Radiology
Chest X-Ray Diagnosis. [Ritvo] 814
Clinical Roentgenology. Volume III: Lungs and Cardiovascular System. [de Lorimier & others] 87
Obstetrics & Gynecology: Series of Monographs. Obstetrical Roentgenology. [Berman] 422
Rush, L. L., Atlas of Rush Pin Technics, 607
Rushmer, R. F., Cardiac Diagnosis, Physiologic Approach, 1267
Russell, P. F., Man's Mastery of Malaria, 725
Shearer's Manual of Human Dissection. [Tobin] 247
Short, J. J., Clinical Care of the Diabetic, 422
Shoulder and Environs. [Bateman] 1181
Slobody, L. B., Survey of Clinical Pediatrics, 1098
Smolka, H., and Soost, H. J., Grundriss und Atlas der gynäkologischen Cytodiagnostik, 1372
Social Work
Pediatric Years: Guide in Pediatrics for Workers in Health, Education and Welfare. [Spekter] 517
Speech
Speech after Laryngectomy. [DiCarlo & others] 919
Stuttering in Children and Adults. [Johnson] 1537
Spekter, L., Pediatric Years, 517
Spiegel, E. A., editor, Progress in Neurology and Psychiatry, Volume X, 338
Spivack, J. L., Surgical Technic of Abdominal Operations, 1537
Spock, B., Feeding Your Baby and Child, 1003
Stereoscopic Atlas of Human Anatomy. Section III: Upper Extremity. [Bassett] 1373
Sternberg, T. H., and Newcomer, V. D., editors, Therapy of Fungus Diseases, 724
Stuttering in Children and Adults. [Johnson] 1537
Subacute Bacterial Endocarditis. [Kerr] 1182
Surgery
Atlas of General Surgery. [Wilder] 1181
Henry Ford Hospital International Symposium on Cardiovascular Surgery. [Lam] 607
Mechanisms of Healing in Human Wounds. [Hartwell] 338; (correction) 688
Medical Department, United States Army, Surgery in World War II. [Elkin & DeBakey] 1181
New Concepts in Surgery of the Vascular System. [Holman] 517
Operative Technic in General Surgery. [Cole] 815
Personality Changes Following Frontal Leucotomy. [Tow] 607
Principles and Practice of Surgical Nursing. [Nash] 247
Surgery—Continued
Surgery of the Ambulatory Patient. [Ferguson] 422
Surgery of the Sympathetic. [McGregor] 422
Surgical Technic of Abdominal Operations. [Spivack] 1537
Traité de technique chirurgicale. [Oberlin & others] 814
Symptoms
Relief of Symptoms. [Modell] 150
Tanner, J. M., Growth at Adolescence, 919
Therapeutics
Cornell Conferences on Therapy. Volume Seven. [Gold] 422
Therapy of Fungus Diseases: International Symposium. [Sternberg & Newcomer] 724
Thomas, C. I., Cornea, 724
Thorax
Chest X-Ray Diagnosis. [Ritvo] 814
Thrombosis and Embolism. [Keller & Merz] 607
Tobin, C. E., editor, Shearer's Manual of Human Dissection, 247
Topley and Wilson's Principles of Bacteriology and Immunity in Two Volumes. [Wilson & Miles] 1437
Tow, P. M., Personality Changes Following Frontal Leucotomy, 607
Toxicology
Food Poisoning. [Dack] 1373
Trevor-Roper, P. D., Ophthalmology, 725
Tuberculosis
Atlas of Bronchial Lesions in Pulmonary Tuberculosis. [Dijkstra] 1181
Ciba Foundation Symposium on Experimental Tuberculosis. [Wolstenholme & Cameron] 1003
Ulcers
Mechanisms of Healing in Human Wounds. [Hartwell] 338; (correction) 688
University of Iowa
Stuttering in Children and Adults. [Johnson] 1537
Veirs, E. R., The Lacrimal System, 87
Virtue, R. W., Hypothermic Anesthesia, 815
Viruses
Introduction to Virology. [Dalldorf] 150
Vitamins and Hormones. Volume XIII. [Harris & others] 338
Wallin, J. E. W., Education of Mentally Handicapped Children, 723
Whipple, G. H., Dynamic Equilibrium of Body Proteins, 1437
Wilder, J. R., Atlas of General Surgery, 1181
Williamson, P., Office Procedures, 919
Wilson, G. S., and Miles, A. A., Topley and Wilson's Principles of Bacteriology and Immunity in Two Volumes, 1437
Wohl, M. G., and Goodhart, R. S., editors, Modern Nutrition in Health and Disease, 1267
Wolstenholme, G. E. W., and Cameron, M. P., editors, Ciba Foundation Symposium on Experimental Tuberculosis, 1003
World War II
Medical Department, United States Army, Preventive Medicine in World War II. [Coates & others] 150: 1372
Medical Department, United States Army, Surgery in World War II. [Elkin & DeBakey] 1181
Medical Support of the Army Air Forces in World War II. [Link & Coleman] 247
Wounds
Mechanisms of Healing in Human Wounds. [Hartwell] 338; (correction) 688
Yearbook
Progress in Neurology and Psychiatry, Volume X. [Spiegel] 338

C

C-REACTIVE PROTEIN
level in myocardial infarction. [Goldner] 591—ab
test for inflammatory or tissue-destroying process. 671—E
CADMIUM
poisoning and hypotension, United Kingdom, 1167
CALCIFEROL
treatment of lupus vulgaris. [Marcussen] 322—ab
CALCIFICATION
of arteries in infant, myocardial infarction from. [Traisman] 915—ab
of medial collateral ligament of knee due to trauma, 727
physiologic vertebral ligamentous, aging process. [Smith] 696—ab
CALCIUM
deposits (metastatic), edathamil to remove, blood and urine calcium test problems. [Carr & Frank] 1258—C
Disodium Versenate: See Edathamil
hypervalcemia, severe infantile. [Schlesinger] 1434—ab
radioactive, to study urinary excretion, Austria, 1088
urinary calculi containing, salicylamide and acetylsalicylic acid for. [Prien & Walker] •935

CALIFORNIA
radiologic defense plans in, [Warren & Stein] *1215
San Mateo County Society studies newspaper medical coverage in San Francisco area, [Wilmer] *633; *768; (replies) [McDowell; Wren] 1236; [Ford] 1237; (reply) [Wilmer] 1237
CAMOQUIN: See Amodiaquin
CAMPS
for cardiac children, N. Y., 1336
for diabetic children, Ill., 684
CANADIAN MEDICAL ASSOCIATION
exchange visits with A.M.A. and B.M.A., 1352
CANCER
actinomycin C inhibits growth of Ehrlich and Walker types in rats, United Kingdom, 584
American Cancer Society, (1956 campaign) 882; (doctors' opinions on campaign) [Miscellany] *1171; (fellowships) 1339
A.M.A. Trustees action on proposed state commissions, 1323
carcinogens in soil, United Kingdom, 1353
diagnosis, cecotomy to differentiate from inflammation of diverticulitis? 1185
diagnosis, cervical biopsy by cold-knife conization, [Scott & Reagan] *343
diagnosis (cytologic), Erie County offers, N. Y., 403
diagnosis (cytologic) evaluated, Peru, 75
diagnosis (cytologic) in colon, [Galambos] 325—ab
diagnosis (cytologic), lecture on, 1149
diagnosis in stomach by chymotrypsin lavage, [Klayman; Rubin] 706—ab
diagnosis of carcinoid, United Kingdom, 898
diagnosis, role of general practitioner, [Boles & others] *923
diagnosis, tag day booklet: "How Your Doctor Detects Cancer," Ind., 1242
diagnosis, value of yearly examination in women, [Rutherford & Banks] *1289
diagnostic smears not fixed in alcohol-ether dependable? 1099
etiology, in esophagus, [Mosbech] 1173—ab
etiology in larynx, epidemiological approach, [Wynder & others] *1384
etiology in liver in Bantus, [Berman] 804—ab
etiology in lung, (waterpipe smoking?) 218; (bronchitis in, England) 314; (industrial aspects) [Breslow] 1096—ab; (air pollution, Italy) 1164; (United Kingdom) 1430
etiology: trauma? 342
etiology: x-ray therapy, [Beutel] 918—ab
extragenital, and pregnancy, [Hebold] 999—ab
Genesee County observes Cancer Day, Mich., 1242
granulosa cell, in pregnancy with abruptio placenta, hemoperitoneum and intestinal obstruction, [Barrett] 1265—ab
in children, statistics on, Colombia, 1162
in medical otolaryngology, [Davison] *105
incidence, Colombia, 1162
metastases, breast: adrenalectomy for, [Hughes-Jones] 327—ab
metastases, breast; endocrines for, [Pearson] 324—ab
metastases, cancer to cancer [Schneider] 334—ab
metastases, liver; radon implants feasible? 727
metastases, lungs from thyroid, [Catz & Starr] *1046
metastases, prostate; hemorrhagic diathesis with, [Prout & others] *840
metastases, testicular; chemotherapy for, [Wildermuth] 146—ab
Pan American Cancer Cytology Congress (first), 1957, 125
precancerous condition: intestinal metaplasia in gastric mucosa, [Morson] 514—ab
precancerous condition of skin, cystostatic pomades for, Switzerland, 995
predisposition, cancer deaths in Switzerland, 1952, 316
prevent recurrence in animals by mechlorethamine, Austria, 794
serodiagnosis, [Povoa] 245—ab
spread in lymphatic system, [Zeidman] 721—ab
symposium, Royal College of Surgeons, 501
terebrating, of scalp and forehead, Austria, 1161
terminal, morphine plus amiphenazole for pain, United Kingdom, 1351
transplantation, cell seeding in surgery [Smith] 711—ab; (danger in papillary thyroid) [Crile] 1263—ab
treatment, Hoxsey: FDA warning on, 1423
CANDIDA: See Moniliasis
CANNED FOODS
safety after long storage, 250
CANNON, WALTER B. (1871-1945)
case of: mycosis fungoides, [Aub] 333—ab
CANTOR, PAUL D., physician member of District of Columbia bar, 402
CAPILLARIES
hemangiomas (congenital) of parotid gland, [Campbell] 999—ab
microscopy of conjunctiva and nailbed in rheumatic fever, [Davis] 709—ab
nevi, P³² for, [Roe] 421—ab
pericardial lymphatic, caliber in piglets, dogs and man? 520
CAPITAL PUNISHMENT
Hunterian Society debates necessity of, England, 413
CARBACHOL
treatment plus nitrofurantoin in neurogenic bladder infections [Stewart & Rowe] *1221
CARBARSONE
toxicity: hepatitis, [Nelson] *764
CARBAZOCHROME SALICYLATE
N.N.R., 119
CARBIMAZOLE
treatment of thyrotoxicosis, [Kirkeby] 605—ab
CARBOHYDRATES
metabolism and barbiturates, United Kingdom, 585
metabolism, postoperative, Peru, 895
CARBON
radioactive tagged tyrosine to study melanoma, Switzerland, 414
CARBON DIOXIDE
effect on respiration, Peru, 315
CARBON MONOXIDE
poisoning increased, United Kingdom, 702
poisoning, symptoms, Switzerland, 1531
toxicity: peripheral nerve lesions during coma from, [Olson] *39
CARBONIC ANHYDRASE INHIBITORS: See Acetazolamide
CARBUNCLE
treatment, penicillin, 340; (correction) 985
CARBUTAMIDE
oral hypoglycemic agent, [Ridolfo & Kirtley] *1285; 1320—E
CARCINOID
test for, United Kingdom, 898
CARCINOMA: See Cancer
CARDIOLOGY: See Heart
CARDIOSPASM: See Stomach
CARDIOVASCULAR DISEASE
complicating hypertension, [Smithwick & others] *1023; (Smithwick's sympathectomy vs. medical therapy) [White] *1027
complicating hypertensive renal disease, lung consolidation as sign, [Howes] 1260—ab
kidney disease with, prognosis; insurance mortality study, [Bolt & Lew] *736
prophylaxis, Switzerland, 414
rehabilitation of veterans with, 309
WHO meeting report, 316
CARDIOVASCULAR SYSTEM
collapse in acute poliomyelitis, [Hildes] 1173—ab
deterioration in outlook for subacute bacterial endocarditis, [Mendelson & others] *437
Rauwolfia effects on, [Lewis & others] *622
surgery (experimental), hypothermia for, N. Z., 229
CAROTID GLAND
tumor, recurrent; [Arean] 128—ab
CARTILAGE
homografts, uptake of labelled sulphate by, [Wyburn] 325—ab
CAST
colored, for children, [Karbelnig] 587—C
CASTRATION: See Sterilization, Sexual
CATARACT
dinitrophenol cause years later? 1538
in rats from Myleran, [Solomon] 604—ab
CATHARTICS
prolonged use, x-ray study of intestine after, [Heilbrun] 216—ab
CATHETERIZATION
cardiac, in children, anesthesia for, [Fieldman] 516—ab
CECUM
cecotomy to differentiate carcinoma from inflammation of diverticulitis? 1185
CELIAC DISEASE
observations on, [Weijers] 718—ab
CELLS
cell respiration inhibited by glucose, Austria, 794
L. E., as sign of hydralazine toxicity, [Comens & Schroeder] *1134
CENTRAL AMERICA
Institute of Nutrition of Central America and Panama, program, (Council statement) *561
CEPHALALGIA
histaminic, guest editorial by Dr. Horton, 468—E; (correction) 884
CEREBELLUM
softening with basilar thrombosis after neck manipulation, [Ford] 1264—ab
CEREBRAL HEMORRHAGE: See Brain; Medicolegal Abstracts at end of letter M
CEREBROSPINAL FLUID
complement fixing antibodies in, in coccidioidal meningitis, [Smith & others] *546
isoniazid in plasma and, relation after oral use, [Malosetti] 238—ab
pressure, urea effect on, [Javid & Settlage] *943
rhinorrhea, submucous resection after face injuries with: how long wait? 151
Treponema pallidum immobilization test on spinal fluid, [Miller & others] *1394
CESAREAN SECTION
accepted rate for hospitals, 920; 921
4 or more, [McNally & Fitzpatrick] *1005
prognosis, insurance mortality study, [Bolt & Lew] *736
tubal ligation indication for? 920
CHAGAS' Disease: See Trypanosomiasis
CHARTS
to record child's growth and performance, [Kimball] *1033
CHEMICAL WARFARE
civil defense planning and requirements, [Whitney] *1195
USPHS responsibilities in civil defense, [Hozier] *1206; [Christensen] *1209
CHEMICALS
adhesive arachnoiditis and vascular blockage from, [Hurst] 516—ab
changes at allergy sites, India, 993
granulomas induced by, N. Z., 229
health hazards, A.M.A. symposium, 65
in etiology of occupational dermatoses, [Klauder] *442
in food, artificial sweeteners, (Council statement) *875
skin testing, polyvalent sensitivity develops, [von Haam] 603—ab
CHEMOPALLIDECTOMY of globus pallidus for Parkinsonism, [Cooper & others] *1444
CHEMOTHERAPY: See also under specific drugs
differential selection of drugs, [Robitzek] 1534—ab
in leprosy, [Doull] 907—ab
in leukemia, status, (Council report) *1228
prolonged in tuberculosis of lung, [Hoyle] 707—ab; (United Kingdom) 1166
side effects, Austrian congress discusses, 694
CHEST: See Thorax
CHEVALIER JACKSON silver tracheostomy tube (uncuffed) for artificial respiration, [Mörch & others] *864
CHICAGO welcomes A.M.A. meeting (photos) 1478
CHILDBIRTH: See Labor; Medicolegal Abstracts at end of letter M
CHILDREN
abdominal tuberculosis in, x-ray diagnosis, [Dittrich] 906—ab
acute abdominal conditions in, Brazil, 1252
anesthesia for cardiac catheterization in, [Fieldman] 516—ab
antipyretic-analgesic for, N-acetyl-p-aminophenol, [Cornely & Ritter] *1219
asthma in, [Wright] 243—ab
camps for, (diabetic, Ill.) 684; (cardiac, N. Y.) 1336
cardiospasm in, [Palazzo] 243—ab
care in Grand Rapids, Mich., (Council article) *1072
cerebral palsy in, zoxazolamine for, [Abrahamsen & Baird] *749
chylous ascites in, [Whittlesey] 717—ab
drinking fluoridated and nonfluoridated water, albumin and formed elements in urine of, [Schlesinger & others] *21
epidemic respiratory infections in, United Kingdom, 1255
femur fractures in, traction for, [Stryker] *388
fractures in, propose colored casts, [Krabelnig] 587—C
handicapped, clinics for, (Ill.) 982; 1336; 1418; (Wis.) 1150;
handicapped, services manual, 65
health implications of White House conference on education, 120—E
Hospitals for: See Hospitals, children's
hypoproteinemia and agammaglobulinemia differentiated in, France, 1530
hypoproteinemia with hyperaminoaciduria in, France, 1530
innocent systolic murmurs in, [Stuckey] 716—ab
kyphosis in, [Ferguson] 1000—ab
mentally retarded, clinics for, (U. of Rochester) 570; (U. of Washington) 571
neglect and intelligence, United Kingdom, 1352
nephroblastoma in, United Kingdom, 1430
nitrofurantoin for urinary infections in, [Stewart & Rowe] *1221
obesity in, United Kingdom, 702
of college graduates, Scripps Foundation study, 65
pediatrician examines mother also, [Kimball] *1033
poisoning, alkali burns of esophagus, [Carver & others] *1447
poisoning, kerosene, 1410—E
poisoning, milk powder, United Kingdom, 1430
sickle-cell anemia in, clinical signs, [Scott] 601—ab
size, increase in, United Kingdom, 702
staphylococcal infections in, [Taft] 915—ab
stretch socks for, possible harm to feet, [Harell] 997—C
torticollis (acquired) in, [Donaldson] *458
traumatic dislocation of head of radius in, [Stelling & Cote] *732
tuberculosis detection in, France, 992
tuberculosis incidence in, Peru, 1253
tuberculosis (primary) treatment in, [Raynaud] 1435—ab
tuberculosis survey in Belgium schools, 1947-55, [Jeurissen] 337—ab
vaccines for Asiatic travel, dosage, 817
who take no cod-liver oil, England, 72

CHILLS
in heat application a sound treatment? 688
CHLORAMPHENICOL
intramuscular use, N.N.R., 671
palmitate, N.N.R., 119
treatment of leptospirosis fails, United Kingdom, 1089
treatment of salmonellosis, India, 892
CHLORIDES
in serum, bedside determination, Scribner method, 424
CHLORINE
poisoning in public baths, United Kingdom, 702
CHLOROCORTISOL
effect on skin homotransplants, N. Z., 229
β,β'-CHLOROETHYL SULFIDE (mustard gas)
poisoning in veterans, bronchitis relation to cancer in, England, 314
CHLOROETHYLAMINES: See Nitrogen Mustard
β-(di-2-CHLOROETHYLAMINO)-PHENYLBUTYRIC ACID
treatment of malignant lymphomas, England, 132; [Galton] 331—ab
CHLOROMYCETIN: See Chloramphenicol
2-CHLOROPROPYL-DI-(2-CHLOROETHYL)-AMINE HYDROCHLORIDE
treatment of Hodgkin's disease, United Kingdom, 1429
CHLOROQUINE: See also Iodoquinolines
treatment of lupus erythematosus, (Switzerland) 414; [Leeper] 1001—ab
treatment of rosacea, [Brodthagen] 1001—ab; (United Kingdom) 1352
treatment status in amebiasis, (Council report) *1230
CHLORPROMAZINE
amobarbital and phenobarbital with, for sleep in ophthalmology, France, 1428
danger of combining with electric shock, [Epstein] 503—C
effect on liver, Switzerland, 156
effect on stomach secretion, [Haverback] 332—ab
hydrochloride, N.N.R., 287
to induce rest in poliomyelitis, [Brehme] 89—ab
toxicity: blood dyscrasias, (Council report) 287
toxicity: dermatitis in nurses and pharmacists, England, 74
toxicity: jaundice, [Isaacs] 146—ab; [White] 720—ab; [Lindsay] 813—ab; [Mengur] 1178—ab
toxicity: laryngeal edema, [Brill] 1355—C
treatment of gastrointestinal diseases, [Asher] *1281
treatment of hyperemesis gravidarum, (Council report) *208
treatment of mental disorders, [Hwat] 143—ab; (reserpine compared) [Kovitz] 143—ab; [Zeller & others] *179; (Italian symposium) 697
treatment of postanesthetic nausea, vomiting and retching, [Knapp & Beecher] *376
treatment of senile agitation, [Settel] 888—ab; [Terman] 1176—ab
treatment of tetanus, [Cole] 321—ab; (United Kingdom) 1352
vs. zoxazolamine as muscle relaxant, [Amols] *742
CHLORTETRACYCLINE (Aureomycin)
bacterial resistance, serial subculture in mixtures effects on, [Molomut & others] *967
food preservative, FDA approved, 779—E
treatment of acute mastitis, [Gunther] 1434—ab
treatment of liver cirrhosis, [David] 719—ab
CHOLE—: See Bile Ducts; Biliary Tract; Gallbladder
CHOLEDYL: See Oxtriphylline
CHOLERA
vaccination for children for Asiatic travel, 817
CHOLESTEROL
diet, and coronary disease, England, 313
In Blood: See Blood
CHOLINE
in pathogenesis and treatment of fatty liver cirrhosis, (Council article) [Gabunda] *969
Theophyllinate: See Oxtriphylline
CHOLOGRAFIN: See Iodipamide
CHONDROMA
simulating bone tumors, [Collins & Collins] *431
CHOROIDEREMIA
in woman 26, hereditary aspects, 727
CHRISTIAN SCIENCE
vs. hypnotism in pregnancy and labor, (reply) [Dennis] 76—C
CHRISTMAS DISEASE
in negro boy, [Golding] 418—ab
CHROMIUM
radioactive, to label erythrocytes to measure blood volume, [Walser & others] *854; (Meyer) *1312
CHRONICALLY ILL: See Disease, chronic
CHYLE
chylous ascites in childhood, [Whittlesey] 717—ab
CHYMOTRYPSIN
lavage to diagnose gastric cancer, [Klayman; Rubin] 706—ab
CICATRIX
cavities after treating caseous pneumonia, Switzerland, 1428
F. B. I. seeks identity of man treated for X-shaped wound on face, 215
laparotomy, endometriosis 10 years after, [Fernandez-Ruiz] 1266—ab
CIGARETTES: See Tobacco
CIRCUMCISION
in infancy, penis cancer in man after, [Paquin] 339—ab
CITIES AND TOWNS
sarcoidosis epidemiology relation to urban-rural residence, [Gentry] 721—ab
CIVILIAN DEFENSE
A.M.A. information on, 1413
civilian doctor and security, (reply) [Hahn & Raffensperger] 899—C
identification tags for civilians, Sweden, 698
mobile medical support for, [Olson & others] *1202; [Howard & others] *1211
National Medical Defense Conference, (Nov. 1955 excerpts and June 1955 proceeding available) 751; (June 9, 1956 meeting) 1233; (papers read in June 1955) [Whitney] *1195; [Olson & others] *1202; [Hozier] *1206; [Christensen] *1209; [Warren & Stein] *1215
outline guide to organize emergency hospitals, N. Y., 685
physicians' course at UCLA, 401
planning and requirements, [Whitney] *1195
radiological defense plans in California, [Warren & Stein] *1215
responsibilities of USPHS, [Hozier] *1206; [Christensen] *1209
CLAMP
noncrushing, for gastroenterological surgery, [Reinhoff] *1136
CLIMATE
acclimatization can be congenital or acquired, 1
Fen in relation to building medical unit, [Business Practice] *233
industrial lead poisoning relation to, [Shiels] 335—ab
CLIP
for office and laboratory, from ready-made bow ties, [Human] 76—C
CLOPANE: See Cyclopentamine
CLORAZETIN WCS-90: See Monoxychlorosene
CLOTHING: See also Shoes
anthrax from goat hair in coat linings, 52—E; (reply) [Gold] 1091—C
clothes dryer destroy ringworm eggs? 1538
dermatitis from stockings, United Kingdom, 1256
in operating rooms, nylon safe? 88
stretch socks, possible harm to growing feet, [Hazel] 297—C
COCARBOXYLASE
treatment of severe tuberculosis, [Petruccioli] 1262—ab
COCCIDIODOMYCOSIS
39,500 serologic test patterns in, [Smith & others] *516
COD LIVER OIL
study of children who do not take, England, 72
CODEINE
treatment of cough, United Kingdom, 1429
COFFEE
wrist complication in operators of espresso dispensers, United Kingdom, 1532
COFFIN
glass-topped for body of Earl of Bothwell, 928
COITUS
aspermia during, can man be helped? 249
COLCEMID: See Desacetylmethylcolchicine
COLCHICINE
in cytostatic pomade for basal cell carcinoma of precancerous skin lesions, Switzerland, 995
COLD
Body application: See Hibernation, Artificial
damp vs. dry, in heat exchange of unclothed man, [Burton] 722—ab
injury, trauma of, France, 1349
knife conization in cervical biopsy, [Scott & Reagan] *343
COLDS
"Common Cold." A.M.A. radio transcripts, 1333
COLITIS
amebic, arsthinol for, [Brown & others] *980; 993—E
balantidial, Peru, 315
hemorrhagic, Switzerland, 1350
ulcerative, ACTH and cortisone for, [Maltby] 805—ab; (effect on surgery) [Hayes] 1368—ab
ulcerative, antibody-coated red blood cells in, [Lorber] 594—ab
ulcerative, cortisone for, England, 73
ulcerative, incidence, Switzerland, 316
ulcerative (intractable), prefrontal lobotomy for, [Levy & others] *1277
COLLAGEN DISEASE
etiology, interstitial pneumonitis in dermatomyositis, [Mills & Mathews] *1467
renal, in recurrent calculi, salicylates for, [Baker & Connelly] *1166
COLLAPSE: See Shock
COLLEGE: See also University
of General Practitioners, 3rd annual report, United Kingdom, 896
of Physicians and Surgeons of South Africa incorporated in 1955, 228
COLLOIDS
in urine, [Hillenbrand] 330—ab
COLON
contractions to study constipation; potassium effect on, France, 992
diverticulitis with perforation during cortisone and ACTH, [Palmer] 596—ab
diverticulosis in Saint's triad, surgery for, [Palmer] 241—ab
exfoliative cytology to diagnose cancer, [Galambos] 325—ab
megacolon, Brazil, 892
polyposis with osteomatosis and soft-tissue tumors: familial syndrome, [Weiner] 142—ab
tumors, hemangioma, [Bailey & others] *658
COLORING
matters in food, recommendations on, United Kingdom, 585
COLOSTOMY
control, United Kingdom, 1532
COLUMBIA RIVER
low-level radioactivity in, [Henderson] 1180—ab
COMA
peripheral nerve lesions during, [Olsen] *39
COMMISSION
on care and Treatment of Chronically Ill, Aged, and Infirm, report (cooperative) on aged in mental hospitals, [Shindell & Cornfield] *1121
on Chronic Illness terminates activities in June 1956, 292—E; 1145—E; (role in preventing chronic diseases) [Scheele] *1114
COMMISSUROTOMY: See Mitral Valve
COMMUNICABLE DISEASES
control in civil defense, [Whitney] *1195; (USPHS responsibilities) [Hozier] *1206; [Christensen] *1209
control, physicians and public health departments, [Pinckney] *1150
COMMUNITY
programs of county medical societies, [Council article] *564
COMPARTMENTATION
in adaptability of child, [Kimball] *1033
COMPLEMENT
autodeviation complicating syphilis diagnostic tests, Switzerland, 995
fixation in coccidioidomycosis, [Smith & others] *516
fixation in poliomyelitis contacts, [Berger] 1368—ab
COMPOUNDS (listed by number)
3 G.T., Ireland, 1253
10 A.T., [Sandock] *659
55-BZ, [Ridolfo & Kirtley] *1285; 1320—E
1340 C.B., England, 132; [Galton] 331—ab
2254 RP, [Loubatieres] 1536—ab
CONGRESS: See also Bill of Societies and Other Organizations at end of letter S
of Austrian Surgeons discusses stomach surgery, 1251
of Italian Society of Internal Medicine discusses adrenals, 582
of Otorhinolaryngology, Paris, October 1956, 1349
on Industrial Health, 16th annual, 53—E; (Program) 56; (report) 676
CONIZATION: See Uterus Cancer
CONJUNCTIVA
capillary signs of rheumatic fever, [Davis] 709—ab
CONNECTICUT
state mental hospitals, the aged in, [Shindell & Cornfield] *1121
CONN'S SYNDROME
complications, severe hypertension, [Chalmers] 1432—ab
CONSTIPATION: See also Cathartics
colon contractions to study; potassium effect on, France, 992
CONTAGIOUS DISEASES: See Communicable Diseases; Infectious Disease
CONTRACEPTION
family planning, United Kingdom, 1430
unnecessary after last menses, 152; (reply: advise for 2 years) [Calderone] 1100
use in marriage conflicts, Switzerland, 1530
CONTRACTURE
Dupuytren's, hydrocortisone for, [Zacharias] 421—ab
Dupuytren's, prognosis; treatment, [Tubiana] 597—ab
Dupuytren's, skin graft for [Conway] 240—ab
CONVULSIONS: See also Eclampsia
from prednisone, [Schroeder & Sherman] 1354—C
in magnesium deficiency, (Council report) [Flink] *1406
Therapeutic: See Electric shock therapy; Insulin shock
treatment, diphenylhydantoin sodium; [Murphy & Schwab] *385
COOKS
shortage in hospitals, United Kingdom, 702
syphilis positive serotests but no disease in, danger of transmission? 1100

COOLEY'S Anemia: Trait: See Leptocytosis, hereditary
COOPERATING
Committee on Graduates of Foreign Medical Schools, report, 978
COPPER
in food, permissible limits, United Kingdom, 1166
metabolism in normal man and in hepatolenticular degeneration, [Bush] 594—ab
mobilization in hepatolenticular degeneration by dimercaprol and edathamil calcium disodium, United Kingdom, 1353
reducing steroids excretion in psychiatric disorders, [Merivale] 599—ab
ricinoleate to control schistosomes, Brazil, 72
COR PULMONALE: See Heart hypertrophy
CORNEA: See Keratoconus
CORNELL UNIVERSITY
course in hospital administration, 881
CORONER
medicolegal office evaluated, autopsy index as comparative standard, (replies) [Turkel] 503—C; [Schaefer] 587—C
CORPORA CAVERNOSA
induration, possibly tumor metastases, (reply) [Paquin & Roland] 610
CORTEF: See Hydrocortisone
CORTICOSTEROID HORMONES
effect on serum bilirubin, [Eanet] 508—ab
effect on surgery for ulcerative colitis, [Hayes] 1368—ab
supplies, United Kingdom, 700
treatment of esophageal erosion, Austria, 1426
treatment of lymphomas, [Spurr] 591—ab
treatment of multiple myeloma with bone pain, 1374
treatment of multiple rheumatoid arthritis, [Marie] 1369—ab
treatment of tuberculosis, France, 1162
treatment of tuberculous meningitis, [Boudin] 1262—ab
CORTICOTROPIN (ACTH)
effects, British gastroenterologists discuss, 313
toxicity: colon diverticulitis with perforation, [Palmer] 596—ab
toxicity: pneumonia symptoms suppressed, [Page] 239—ab
treatment of chronic rheumatoid arthritis, [Forsch] 595—ab
treatment of fulminant hepatitis, [Shane] 804—ab
treatment of hyperemesis gravidarum, [Järvinen] 428—ab; (Finland) 580
treatment of nephrosis, [Frederikse] 329—ab
treatment of nephrotic syndrome in children, [Rance] 716—ab
treatment of pemphigus, [Nelson] 244—ab
treatment of pemphigus vulgaris (long term), [Stoughton] *1041
treatment of premenstrual eczema, [Greenblatt] 1186
treatment of Reiter's syndrome, [Foxworthy] 905—ab
treatment of rheumatic carditis, [Wilson & Lim] *1457
treatment of rheumatic fever, blood antistreptolysin and streptococcal antihyaluronidase after, [Harris] 1096—ab
treatment of rheumatic fever, cardiologic effects, [Harris] 1095—ab
treatment of serum sickness and penicillin reactions, [Fitzgerald] 803—ab
treatment of thyroiditis, [Hoyne] 710—ab
treatment of thyrotoxicosis, France, 1252; [Devcourt] 1432—ab
treatment of ulcerative colitis, [Malthy] 803—ab
treatment status in leukemias, (Council report) *1228
CORTISONE
effect on nucleic acid in leukemic elements, [Gavoste] 812—ab
effect on rheumatic cardiac lesions after mitral commissurotomy, [Gil] 240—ab
Hydro-: See Hydrocortisone
neuropsychiatric signs in lupus erythematosus falsely attributed to, [Clark & Bailey] *455
toxicity: colon diverticulitis with perforation, [Palmer] 596—ab
toxicity: pneumonia symptoms suppressed, [Page] 239—ab
treatment and/or orchiectomy with resection for prostate cancer, [Pool & Thompson] *833
treatment of allergy compared to prednisone, [Feinberg & Feinberg] *264
treatment of chronic rheumatoid arthritis, [Forsch] 595—ab
treatment of fulminant hepatitis, [Shane] 804—ab
treatment of hay fever, Sweden, 896
treatment of nephrotic syndrome in children, [Rance] 716—ab
treatment of osteitis deformans: 250
treatment of pemphigus, [Nelson] 244—ab
treatment of polyarthritis, Switzerland, 229
treatment of post-myocardial-infarction syndrome, [Dressler] *1379
treatment of pulmonary sarcoidosis, France, 695
CORTISONE—Continued
treatment of Reiter's syndrome, [Foxworthy] 905—ab
treatment of rheumatic carditis, [Wilson & Lim] *1457
treatment of rheumatic fever, blood antistreptolysin and streptococcal antihyaluronidase after, [Harris] 1096—ab
treatment of rheumatic fever, cardiologic effects, [Harris] 1095—ab
treatment of serum sickness and penicillin reactions, [Fitzgerald] 803—ab
treatment of thyroiditis, [Hoyne] 710—ab
treatment of thyrotoxicosis, France, 1252; [Devcourt] 1432—ab
treatment of ulcerative colitis, (England) 73; [Malthy] 803—ab
treatment (paravertebral) in spine osteoarthritis, (replies) [Pruce] 899—C; [Cohen] 1355—C
treatment status in leukemias, (Council report) *1228
CORTRIL: See Hydrocortisone
COSMETICS
allergic to urea-formaldehyde resin facial tissues, [Peck & Palitz] *1226
hair loss from Selsun shampoo, [Grover] *1397
COSTEN'S SYNDROME: See Jaws
COUGH
from trichloroethylene exposure? 248
tests for antitussives, United Kingdom, 1429
COUGHLIN CASE
test of tax deduction of postgraduate education expenses, [Medicine and the Law] *399
COUNCIL of International Organizations in Medical Sciences, work of, [Visscher] 135—C
COXSACKIE VIRUS
group B, myocarditis in the newborn from, [Javett] 810—ab
CRANIAL SUTURE (Fontanel)
apparent rupture by leukemia, [Hitzig] 84—ab
CRANIUM
osteitis deformans of, with psychoses, France, 1163
trauma, angiography to evaluate, [Lofstrom] 918—ab
CREAM
sweet and sour, any chemical difference? Can butter be made from sour cream? 342
CRERAR (JOHN) LIBRARY: See John Crerar Library
CRIME
as cause of death, medicolegal office evaluated, (replies) [Turkel] 503—C; [Schaefer] 587—C
suicide not serious crime, United Kingdom, 702
CRIMINALS
Wanted by FBI: See Federal Bureau of Investigation
CRIPPLED
Nuffield Orthopedic Center to study crippling diseases and injuries, 798
CUBITUS VALGUS
from humeral fracture reduction failures, [Milch] *641
CUFF
pneumatic, for temporary occlusion of arteries, [Gardner & Salmoiraghi] *1224
CURARE
treatment of severest tetanus, [Mollaret] 80—ab
CUSHING'S SYNDROME
Italian congress discusses, 882
CYANACETIC ACID HYDRAZIDE
treatment of pulmonary tuberculosis, [Sermbe] 147—ab
CYANOCOBALAMIN (vitamin B12)
exemption of prescribing, Ministry of Health discusses, England, 314
radioactive, to differentiate achylia gastrica and achlorhydria, [MacLean] 79—ab
treatment (intranasal) of pernicious anemia, [Monto] 137—ab
treatment, other uses than in pernicious anemia, 339
CYANOSIS
episodes of collapse with, in diabetic woman; nervous involvement likely, 609
in silicosis, [Tronchetti] 86—ab
CYCLAINE: See Hexylcaine Hydrochloride
CYCLAMATES
as sweetening agents, (Council statement) *875
CYCLIZINE HYDROCHLORIDE
treatment of motion sickness aboard transport ships, *755; (correction) 1081
CYCLODIALYSIS
for keratoconus not recommended, 249
CYCLOGYL: See Cyclopentolate Hydrochloride
CYCLOPENTAMINE HYDROCHLORIDE
treatment plus isoproterenol in pulmonary emphysema, [Leslie & others] *1125
CYCLOPENTOLATE HYDROCHLORIDE
tests and standards, 1050
CYCLOSERINE
new antibiotic and tuberculostatic [Ravina] 604—ab
CYLINDER
crossed, in refraction, value, 1183
CYTELLIN: See Sitesterols

D

DAPT: See Amiphenazole
DBED: See Benzathine Penicillin G
DACRON
allergy to, desensitize? 1438
DAPTAZOLE: See Amiphenazole
DEAF-MUTISM
incidence decreasing due to goiter prevention with iodized salt, Switzerland, 995
DEAFNESS: See also Hearing
during pregnancy, diagnosis, 1538
portable telephone amplifier, [Hosmer] *285
scholarships in lip reading by American Hearing Society, 572
DEATH
Accidental: See "Accidental Death" under Medicolegal Abstracts at end of letter M
cause of, agranulocytosis from actinomycin C, [Janbon] 605—ab
cause of, anesthesia, United Kingdom, 699: (hexebarbital) 1532
cause of, aplastic anemia after Nuvarone, [Isaacson & others] *1311
cause of, autopsy index as comparative standard, (replies) [Turkel] 503—C; [Schaefer] 587—C
cause of, gangrenous cholecystitis and peritonitis after unrelated surgery, [Levin] *1040
cause of, heart arrest during surgery, [Briggs & others] *1439
cause of, micrococcic enteritis from antibiotics, (Denmark) 412; (in surgical gynecology) [Baca] 810—ab; (enterocolitis) [Cuningham] 1175—ab
cause of, PAS and streptomycin hypersensitivity, [Hansen] 509—ab
cause of, penicillin, [Peters] 1178—ab
cause of, penicillin, Denmark, 412; (reply: problem of telling layman) [Troan] 1258—C
cause of, suppression of pneumonia symptoms after cortisone and ACTH, [Page] 239—ab
caused by treatment, United Kingdom, 1353
of Physicians: See list of Deaths at end of letter D
Rate: See Vital Statistics
DECOMPRESSION
operative, intestinal tubes for, [Smith] *266
DECORTIN: See Prednisone
DEFICIENCY DISEASE
multiple, after gastrectomy for ulcer, [Morin] 1264—ab
DEGENERATIVE Joint Disease: See Joints
DEGLUTITION: See Swallowing
DEHYDRATION
procaine for toxicosis from gastroenteritis in nurslings, [Giusti] 1000—ab
DELTACORTENE: See Prednisone
DELVINAL: See Vinbarbital
DEMECOLCIN: See Desacetylmethylcolchicine
DEMENTIA
paralytica incidence after early syphilis treatment, Switzerland, 995
presenile (Jakob), corticostriospinal degeneration, [Bornstein] 600—ab
DEMENTIA PRECOX: See Schizophrenic Reactions
DEMEROL: See Meperidine
DENTIFRICES
British Dental Ass'n. denies that any prevents decay, 315; 702
DENTISTRY
civil defense planning and requirements, [Whitney] *1195
shortage of dentists, propose bill to alleviate, United Kingdom, 897
DEPIGMENTATION
of face not due to fungi, possibly vitiligo or erythema streptogenes, 340
DEPRESSION: See Mental Depression
DERMATITIS
Atopic: See Neurodermatitis
etiology: antiseptic soap, [Blank] *1225
etiology: neomycin, [Epstein] 1355—C
etiology: plastics, detergents, Dacron, Orlon; desensitize? 1438
etiology: stockings, United Kingdom, 1256
Industrial: See Industrial Dermatoses
overtreatment, [Gaul] 1001—ab
seborrheic, hair loss after Selsun shampoo for, [Grover] *1397
DERMATOMYOSITIS
interstitial pneumonitis in, [Mills & Mathews] *1467
DERMATOPHYTOSIS
of feet (acute), experiments on mechanism producing, [Baer & others] *184; 211—E
DERMATOSIS: See Skin disease
Industrial: See Industrial Dermatoses
DESACETYLMETHYLCOLCHICINE
for basal cell carcinoma or precancerous skin lesions, Switzerland, 995
DESOXYEPHEDRINE: See Methamphetamine Hydrochloride
DETERGENTS
adhesive arachnoiditis and vascular blockage from, [Hurst] 516—ab
allergy to, desensitize? 1438

DEXTRAN: See Hydroxletran
DEXTROSE: See Glucose
DIABETES MELLITUS
Alameda-Contra Costa Diabetes Ass'n. dedicated, Calif., 1235
blood sugar high, in obese woman 63, high dosage of insulin dangerous? 248
camp for diabetic children, Ill., 684
coma, thiamine pyrophosphate for, [van Marken Lichtenbelt] 333—ab
complications: collapse with cyanosis; nervous involvement likely, 609
complications: pregnancy, female sex hormones in, [White] 715—ab
complications, renal: low protein diet for, [Allen] 135—C
complications: retinitis, value of Rutin for, (reply) [Krakowka] 610
complications: schizophrenia: insulin shock for, Austria, 499
complications: vascular degeneration, relation to lipid metabolism, Switzerland, 1165
insulin deficiency the same? [Gerritzen] 1173—ab
intravenous glucose tolerance in, [Duncan] 1366—ab
nonantigenes in, England, 227
3 types, [Lawrence] 502—ab
treatment, acetazolamide, Austria, 499
treatment, carbutamide, [Ridolfo & Kirtley] *1285: 1320—E
treatment, isopropylbiadiazol, Austria, 499
treatment, sulfonamides, France, 1089: [Leutscher] 1536—ab
DIACETYLMORPHINE (heroin): See Morphine
DIAGNOSIS
Diagnostic Problems, [Frazier] *774: (comment) [Ray] *775; [Ramos] *1317: (comment) [Loch] *1319
emphasized in union health centers, (Council article) *679
importance in physical medicine; electric current in neuromuscular disease, (reply) [Licht] 76—C
leukocyte count high, with normal differential count significant? 250
mycological, simple office procedures, [Robinson & others] *537
too many tests in old age? Denmark, 694
urine pepsinogen should be routine test, Peru, 315
DIALYSIS: See Kidneys, artificial
2,6-DIAMINO-3-PHENYLAZOPYRIDINE HYDROCHLORIDE
treatment plus sulfa-methylthiadiazole in urinary infections, [Toland & Schwartz] *542
2:4-DIAMINO-5-PHENYLTHIAZOLE: See Aminophenazole
DIAMOX: See Acetazolamide
DIAPHRAGM
Infarction, precordial T waves as sign of, [Wachtel] 709—ab
DIARRHEA
epidemic, of newborn, prevention, [Janssen] 784—ab
heart disease and rectum cancer with, (Diagnostic Problems) [Frazier] *774; (comment) [Ray] *775
DIATHERMY
effect on fracture healing, 818
sonic and electric, modes of action, [Schwan] *191
DIATHESIS
hemorrhagic, in prostate cancer, [Prout & others] *840
DIATRIZOATE SODIUM
in gastrointestinal roentgenoscopy, [Davis & others] *373
DICHLOREN: See Nitrogen Mustard
DICHLOROETHYL SULFIDE: See ββ'Dichloroethyl Sulfide
DIENCEPHALON: See Brain
DIET
amino acid balance, value of supplements in, 608
cholesterol, and coronary disease, England, 313
deficient and resource to alcohol, France, 1163
deficient in women in etiology of larynx cancer, [Wynder & others] *1384
for fibrocystic pancreas, [di Sant'Agnese] *846
for peptic ulcer, [Bell] 984—ab; (normal vs. special, United Kingdom) 1089
for ulcer increase chance of arteriosclerosis? 424
Infant's: See Infants, feeding
low calorie for rheumatism, naturopath criticized, patient died, United Kingdom, 1352
Salt-Free: See under Sodium
vitamin C importance in, (Council report) *1470
DIETHYLENEDIAMINE: See Piperazine hydrate
DIETHYLSTILBESTROL
treatment of pregnant diabetics, [White] 715—ab
DIGESTIVE SYSTEM: See Gastrointestinal Tract
DIGITALIS
treatment plus salicylates and sedation compared to corticosteroids in rheumatic carditis, [Wilson & Lim] *1457
treatment, role of digitoxin, 139
DIHYDRAZINOPHTHALAZINE
to prevent and treat toxemia and eclampsia of pregnancy, [Balacet: Consutta] 82—ab
DIHYDROSTREPTOMYCIN
treatment alone or plus PAS in pulmonary tuberculosis, [Tucker] 322—ab
DIHYDROTACHYSTEROL
treatment of tetany from ovary dysfunction, [Sandvik] *859
DIIODOHYDROXYQUIN
effect on poliomyelitis virus excretion after oral immunization, [Koprowski & others] *934
DILANTIN: See Diphenylhydantoin Sodium
DILLARD UNIVERSITY
dedicates chapel to Dr. T. K. Lawless, 301
DIMENHYDRINATE
for postanesthetic nausea, vomiting, and retching, [Knape & Beecher] *276
for postoperative vomiting, interpreting statistics, (reply) [Zeisler] 318—C
DIMERCAPROL
to mobilize copper (with edathamil) in hepatolenticular degeneration, United Kingdom, 1353
1:4-DIMETHANE SULPHONOXYBUTANE: See Busulfan
DIMETHOXONE
N.N.R., 118
DINITROPHENOL
treatment, will cataracts develop years after? 1538
DIODOQUIN: See Diiodohydroxyquin
2:6-DIOXY-4-METHYL-5-(2-4 DICHLOROETHYL)-AMINOPYRIMIDINE
treatment of Hodgkin's disease, United Kingdom, 1353
DIPAXIN: See Diphenadione
DIPHEMANIL METHYLSULFATE
treatment of asthma in infants, [Bologna] 717—ab
DIPHENADIONE
N.N.R., 776
2-DIPHENYLACETYL-1,3-INDANDIONE: See Diphenadione
DIPHENYLHYDANTOIN SODIUM
treatment of convulsions, [Murphy & Schwab] *285
treatment plus phenobarbital and methamphetamine in epilepsy, [Davidson & Berman] *766
DIPHTHERIA
fever after triple vaccine, 1004
outbreak, Indiana, 1078
prophylaxis, England's Ministry of Health's campaign, 702
tetanus toxoids and, potency and dosage control, [Greenberg & Benoit] *108
DIPHTHERIZOATE, SODIUM
N.N.R., 1143
DIPYLIDIUM
caninum infection in man, treatment, 89
DISABILITY
after removing acoustic neuroma in physician, rehabilitation recommended, 340
Industrial: See Industrial Accidents
Payments for: See also Social Security
payment to veterans, VA report on, 1342
VA plan for patient discharge, 691
DISASTERS: See also Civilian Defense
catastrophic accidents, statistics, 372
organization guide for emergency hospitals, 685
planning for, National Hospital Week emphasizes, 976—E
DISCOVERIES
scientific by medical students, (reply) [Carter & Lockhardt] 504—C
DISEASE
abuse of medical certificates, Sweden, 1165
chronic, Commission on Chronic Illness terminates in June, 292—E; 1145—E
chronic, facilities for, transference of mental patients to, [Shindell & Cornfield] *1121
chronic, home care program, Calif., 982
chronic, progress in prevention, 1949-1956, [Scheele] *1114; 1145—E
chronic, therapeutic duplication in, 780—E
chronic, treat adrenal insufficiency during surgery in, [Howland & others] *1271
effect on growth and maturation, United Kingdom, 584
Industrial: See Industrial Diseases
mutations causing, [Westergaard] 1371—ab
mystery illness in school, England, 315
Nomenclature: See Terminology
treated by physicians, (Bureau article) [Dickinson] *213
DISINFECTION
for swimming pool with constant inflow and outflow, 248
DIURESIS
after malaria for nephrotic syndrome, [Gilbertsen & Bashour] *25
DIURETICS
mercurial freefall, for chronic congestive heart failure, [Makous] 903—ab
treatment of cirrhosis, Peru, 134
DOCTORS: See Physicians
DOBLE BODIES
in leukocytes after burns, [Weiner] 605—ab
DOGS, pericardial lymphatic capillary caliber in, 520
DOOLAN, PAUL D., commended for work on artificial kidney, 888
DOOLEY, THOMAS A., III, lecture on evacuation of Vietnamese, (photo) 576
DOPAN
treatment of Hodgkin's disease, United Kingdom, 1429
DORYL: See Carbachol
DRAGSTEDT, CARL A., guest editorial: personal health log, 1320—E
DRAMAMINE: See Dimenhydrinate
DRESSINGS
abdominal and thoracic surgical wound healing with or without, [Palumbo & others] *533
constrictive to control edema after phlebitis, [Olwin] *1101
occlusive, vs. exposure in experimental burns, [Holman] 913—ab
DRINKING
water, chest pain relieved by, diagnosis? 1099
DRIP
intravenous indicator, United Kingdom, 502
DRUGS
addiction, barbituric acid, [Myschetzky] 1176—ab
addiction, hypnotics, [Wulff] 1176—ab
addiction, meprobamate, [Lemere] 1431—C
addiction, statistics, Denmark, 694
clinical testing, International Congress of Medical Ethics discusses, 695
cost for private patients, United Kingdom, 701
double blindfold technique evaluated, statistical studies, (reply) [Best] 586—C
parenteral administration, 1233—E
radiological exposure, defense against, [Warren & Stein] *1215
request samples, especially vitamins for the Navajos, [Cullen] 115—C
request surplus for Korean hospital, especially for tuberculosis, [Codington] 232—C
samples, economics of prescribing by physicians in rural communities, United Kingdom, 1167
what is a drug; economic problems in prescribing, United Kingdom, 1167
DRUNKENNESS: See Alcoholism
DRYER
for clothes destroy pinworm eggs? 1538
DUCTUS ARTERIOSUS
patent, anomalous coronary artery simulating, [Davis & others] *1047
DUKE UNIVERSITY
course on radiation biology at, 483
DUMPING SYNDROME
after surgery for duodenal ulcer, [Zollinger & Williams] *367
DUODENUM
cancer of infrapapillary part, [Flandreau] 1433—ab
contents in fibrocystic pancreatic disease, [di Sant'Agnese] *846
diverticula cause flatulence, abdominal cramps and nervousness? 520
loop widening, x-ray sign in intestinal lipodystrophy, [Kiser & Bonk] *534
managing stump in gastric resection for ulcer, [Chester] 241—ab
Ulcer: See Peptic Ulcer
DUPLAY'S DISEASE
"calcifying pericholecystitis," Brazil, 313
DUPUYTREN'S Contracture: See Contracture
DUST
exposure, relation to pulmonary emphysema, (reply to Dr. Sander) [Mayer & others] 230—C
lung reactions to, Belgium, 1348
waste, and less smoke in air over Great Britain, 702
DYPHYLLINE
tests and standards, 1051
DYSAUTONOMIA
familial, [Harris] 811—ab
DYSENTERY
Amebic: See Colitis, amebic
in England and Wales increasing, 1255
DYSKINESIA
postcholecystectomy: pancreatitis, sphincteritis and choledocholithiasis as causes, [Walters] *425
DYSPEPSIA: See Indigestion
DYSPHAGIA: See Swallowing
DYSPNEA
from lying on left side, cause, 1374
in silicosis, [Tronchetti] 86—ab
DYSTONIA
neurovegetative, Switzerland, 994
DYSTROPHY, MUSCULAR
charity group formed, United Kingdom, 583
fat deposits on legs in, 1184
genetic mutant of, in mice, research grant for, 684
research grants-in-aid, 304

DEATHS

A

Abercrombie, Anna D. Schultze, 310
Adams, Felix M., 496
Adams, Richard Charles, 577
Adams, William Lanier, 1158
Adamsons, Ilga, 1343
Aderhold, Wiley Austin, 578
Aja y Aja, Nicanor, 1158
Akelaitis, Andrew John Edward, 223
Aldwin, Francis Joseph, 1085
Allen, Alfred George, 1085
Allen, Edward Dewalt, 409
Allen, Francis Withers, 1343
Allen, John Calvin, 990
Allen, John Frank Waite, 1528
Allen, Thomas Dyer, 1085
Allen, Walter Earl, 578
Allen, Wilmar Mason, 790
Allison, Hugh Quitman, 791
Anderson, Frederick Addison, 791
Anderson, William A., 1085
Anthony, Edward Haven, 69
Aragona, Anthony John, 223
Ardolino, Carmine Domenico, 1085
Armstrong, William Buckingham, 578
Ash, William Snively, 1343
Askew, Wesley Lafayette, 791
Atkinson, Charles W., 1424
Atwood, William Goodson, 578
Avery, Walter James, 890
Ayvazian, Haig A., 223

B

Baeseman, R. Winfield, 1158
Baganz, Crawford Norbert, 1085
Baker, Victor Louis, 409
Balfour, Charles Edward, 1424
Ball, Charles Edward, 1344
Ball, Elizabeth Browning, 578
Ballard, Carsie Z., 130
Ballard, Mahlon Blakeslee, 409
Banker, Newton S., 791
Barnes, John McGregor, 890
Barnett, George De Forest, 578
Barney, John Murray, 578
Barnhiser, Von Bergen, 890
Barrett, James Willis Jr., 1528
Bass, Mary Elizabeth, 1157
Batchelor, Thomas Victor, 578
Baxter, George S., 409
Baxter, Stephen Henry, 578
Beatty, Edward Daniel, 130
Becker, Carl Marker, 1085
Behymer, Carroll, 1424
Bell, Loyd Lester, 1085
Benedict, Augustus Palmer, 1528
Benesi, Oscar, 890
Benitez, Frank Francis Arnelio, 890
Benjamin, Clayton Charles, 578
Bennett, Burrell L., 1528
Bennett, Oliver Carlisle, 410
Bennett, Richard Henry, 790
Benson, Charles Prue, 791
Bero, Edward John, 890
Berry, James William, 578
Bertola, Mariana, 410
Bertone, Michael Virgilio, 410
Biedermann-Boehm, Rosella Louise, 223
Bine, Rene, 1158
Bird, Gustavus C., 890
Bird, William Edwin, 1528
Bishop, Albert Henry, 1158
Bishop, George Creed, 1528
Bixby, Oliver Edward, 890
Black, Donald Ray, 70
Blackwell, Oscar L., 1158
Blair, Vilray Papin, 69
Blake, Theodore Miller, 69
Blaney, Cyril Arthur, 1158
Blankmeyer, Harrison Charles, 791
Blasser, Julius Abraham, 791
Blaustein, Maurice L., 70
Blim, Spencer Phelps, 1158
Boehme, Raymond Gustave, 791
Bond, Mabel Cornish, 70
Bookwalter, Harry, 223
Boozer, Albert Isiah, 890
Bordley, James Jr., 1158
Borkow, Philip Stanley, 791
Bornstein, Jack Jacob, 1344
Borst, William L., 791
Bosch, Calvin Christian Fredrick, 1158
Bossyns, Albert Joseph, 70
Bothe, Albert Edward, 310
Boulton, Eleanore F., 130
Bovik, Leslie Enwroth, 1344
Bowdoin, Charles Daniel, 69
Bowen, Ralph, 1157
Bower, Ernest Ziegler, 410
Bower, John Lincoln, 410
Bowers, Henry Wolffe, 1158
Bowing, Harry Herman, 578
Bowles, Marion K., 791
Boyce, John Mayson, 578
Boyd, Kenneth Bray, 890
Boyer, Samuel H. Sr., 410
Bradley, William Austin, 1085
Bragg, Eugene G., 410
Brannin, Edward Bacon, 692
Breakstone, Edgar Osgood, 70
Brewer, Lewis Rawlings, 1085
Briegleb, Charles Ferdinand, 791
Brigham, Charles F., 310
Brillinger, Fred, 791
Britton, James Andrew, 790
Brobst, John William, 1528
Brooks, Paul Bellows, 223
Brooks, Vernon Asbury, 692
Brothers, James Harvey Jr., 1158
Brown, James Richard, 1424
Brown, John Mackenzie, 790
Brown, Oran Alfred, 70
Browning, Ernest Ras, 310
Bryan, James Leslie, 791
Bryant, James Edmond, see Bryant, John Edmond
Bryant, John Edmond, 692
Bryson, Daniel Rice, 1158
Buck, Margaret L. Muehlenbein, 130
Buffum, Erwin W., 223
Buhrer, Emil D., 791
Burch, Julius Caesar, 70
Burdick, Gordon Granger, 890
Burian, Jenny, 1158
Burke, Richard David, 890
Burrows, John Walter, 1158
Burt, Samuel Perry, 130
Butaud, Russell Sterling, 1424
Butler, George Vincent, 310

C

Caccamise, Charles William, 223
Caisse, Georges Emile, 310
Caldwell, Julius Alexander, 70
Callihan, Grover Darwin, 1085
Cameron, Solon, 791
Cammack, Kossuth Rothchild, 1085
Campbell, Eldridge Houston Jr., 1157
Campbell, Franklin Edward Jr., 70
Campbell, William Edgar, 692
Candela, Pompeo Benjamin, 890
Candidus, Eugene William, 130
Cantrell, Benjamin Casey, 130
Capehart, Lovelace Brown Jr., 1158
Carden, Floyd Cornelius, 310
Carmine, Walter Mills, 1424
Carothers, Paul Henry Jacob, 578
Carrig, Milton Henry, 1344
Carroll, John Dennis, 223
Carroll, Joseph Henry, 1528
Carter, Fred Gay, 1528
Casello, John Baptist, 890
Cerasoli, Michael Florinda, 1158
Chance, Albion Somersale, 410
Charr, Robert Kyun Hyun, 1158
Choate, William Gabrial, 496
Chodoff, Louis, 1158
Christian, David A. Jr., 692
Christian, Frank Lamar, 130
Clark, Daniel G., 1344
Clark, Harold Stevens, 409
Clayton, John Wesley, 130
Cleary, Joseph Patrick, 1158
Cleaver, Henry Archer, 1158
Cleverdon, Lawrence A., 1344
Clippinger, Richard D., 70
Clutz, Ralph Robertson, 130
Cochran, Albert M., 410
Cockerham, Howard Lea, 70
Cohan, Abraham, 1344
Cohen, Hymen Leon, 310
Cohen, Louis Harold, 578
Cohen, Samuel E., 130
Colcord, Marshall, 792
Cole, Arthur Vincent, 130
Collins, Archie Greene, 70
Collins, Martin Slaughter, 1085
Colman, Albert C., 890
Colvin, Paul Verlander, 223
Comer, Charles William, 1158
Conley, Dudley Steele, 130
Conn, Harold Russell, 578
Cook, Bryan Jarred, 310
Cook, Carroll Eugene, 792
Cooke, Charles Christopher, 692
Coonley, Frederick, 410
Cooper, Burpee, 310
Cooper, Harry Oliver, 692
Cooper, William Hal, 692
Corbett, Joseph, 70
Corbett, Mitchell Samuel, 1344
Corcoran, William Joseph, 496
Corkery, John Ripley, 1528
Cornick, David J., 792
Cory, Harriet H. Stevens, 70
Cottrell, Judson G., 1528
Cowan, Riley, 310
Cowden, Newell Wilson, 410
Cox, Ann Caroline, 890
Craft, Wiley Boone, 1344
Craig, Ford B., 1528
Crampton, Charles H., 410
Cray, Eugene James, 1158
Creel, Donald Wood, 890
Creighton, Ralph Higby, 223
Crook, Martin, 1158
Crosley, George E., 692
Cross, James Willboarn Sylvester, 70
Crowe, Samuel James, 69
Crowthers, Earl Jonas, 410
Cruice, John Mulchinock, 890
Crume, George P., 310
Crump, George Albert, 1344
Cudd, Alonzo Dean, 792
Curley, William Henry, 891
Currence, Louise Jarvis, 692
Cutler, Haydn Harrison, 792

D

Dammasch, Ferdinand H., 790
Davidson, Edwin Norvell, 891
Davis, Ralph Harold, 891
Davis, Thomas Wallis, 223
Davitt, George Glass, 310
Deatherage, William Newton, 496
Defnet, William Anthony, 1344
Deibel, Henry William, 891
Delany, Lemuel Thackara, 1344
De Nicola, Paul, 1424
Denison, Louis Leslie, 1424
Denman, Austin Van Beuschoten, 692
Denson, Fred Hammond, 578
Des Bois, Philip, 692
Desmond, Michael Ambrose, 1343
De Verges, Philip Cajetan, 579
Devlin, Albert Joseph, 1528
Dismukes, Henry Dodford, 1158
Dodds, Charles Richey, 891
Donahoo, Charles Edward, 792
Donath, Stephan, 496
Donohue, Daniel Joseph, 891
Dorra, Clement, 70
Dowd, Richard Edward, 130
Drake, Paul McCheyne, 891
Drapiewski, Albin Joseph, 1528
Dubpernell, Karl, 1344
Dugan, Thomas J., 792
Dumas, Charles Edward, 792
Dunaway, Louis T., 1344
Dunnick, Milton Carl, 891
Dunshee, Jay Dee, 1343
Dutton, Charles E., 579
Dyar, Burt Alvano, 579

E

Eames, Manley Hunter, 1158
Early, Calvin Sylvester, 579
Earnhardt, John Martin, 1344
Eckfeldt, Thomas Hooper, 310
Edelson, Samuel, 1424
Edwards, Charles Mundy, 1528
Edwards, Martin Russ, 1528
Edwards, Thomson, 496
Eha, Charles Edward, 1528
Eidson, Hilda Wood Allen, 792
Eilers, Harrison, 792
Ellis, James J., 1528
Ellis, John Dayduff, 1528
Elston, George B., 1344
Elworthy, Robert William, 1528
Englehart, Ernest Erwin, 1344
English, William Franklin, 1344
Ensing, Osborn Harris Burnett, 1344
Epstein, Bruno Eric, 1424
Erf, Lowell Ashton, 1158
Ericson, Reinhold Milton, 310
Erikson, Ralph Wennerberg, 1528
Ernst, Charles Henry, 410
Espinoza, Daniel, 70
Evans, John Henry, 311

F

Facey, Frederick Duncan, 1529
Farenholt, Ammen, 1343
Faringer, Howard Reiner, 1159
Farres, Shickry, 990
Farrington, Paul Robert, 130
Fay, Timothy Joseph, 692
Felton, Lester Mahan, 889
Felts, Harvey Austin, 1250
Felts, Wylie Robert, 130
Field, Augustus Marion, 311
Finesilver, Edward Max, 791
Finnegan, William Francis, 1250
Finney, Charles Herman, 1250
Finney, John Marschell, 792
First, Frank H., 1344
Fischbein, Louis, 1424
Fisher, George Singer, 410
Flax, Jacob Louis, 1344
Focer, Raymond Leslie, 891
Foreman, Brady Hugh, 1424
Fowler, Stephen Adolphus, 1344
Fox, William Warren, 70
Fractman, Meyer Bernard, 891
Fractman, Myron Bernard see Fractman, Meyer Bernard
Franz, Adolph Sr., 130
French, Thomas Randolph, 410
Friddell, William F., 223
Friedel, Herman, 792
Friedenwald, Jonas Stein, 69
Froehlich, John Alfred, 692
Froelich, Joseph Conon, 1344
Fronczak, Francis Eustace, 577
Frothingham, George Edward, 70
Fuld, M. Ernst, 224
Furniss, Henry Watson, 1344

G

Gagne, Joseph A., 692
Gallagher, Thomas Morton, 1344
Gardiner, George Logan, 579
Garland, Robert B., 792
Garland, Roy L., 1159
Garner, John Elmo Sr., 1529
Garnett, Algernon Sydney, 692
Garver, Forest Otto, 792
Gedo, Mathias Stephen, 1529
Gibbs, Harley Stuart, 792
Gignoux, John Ernest, 693
Gill, Americus Mack, 224
Gillette, Claude Wesley, 1344
Gillman, Robert Winthrop, 1159
Gilmore, George Harrison, 311
Gindlich, Morris Hyman, 1344
Ginzberg, Raphael, 1424
Gist, William Lucian, 1424
Glasgow, Maude, 224
Glover, Charles A., 1159
Gloyne, Louis Boucher, 890
Glueck, Josephine M. Stransky, 1250
Goad, Norman, 1529
Goeller, Jacob Dan, 791
Good, John Wilson, 792
Goyanes, Everardo, 692
Graber, Benjamin Peter, 693
Grad, Herman, 224
Graf, Carl Herman, 891
Grandoit, Jacques, 1424
Granet, Adolph, 891
Graves, Rex Vale, 311
Gray, Oscar Sylvester, 410
Green, William Arthur, 311
Green, William Louis, 224
Greenwall, Waldron Eugene, 1250
Greider, Frank Croft, 792
Greist, Henry Wireman, 224
Griffin, Michael Joseph, 311
Griffith, George Washington, 792
Griffith, Morgan Everett, 1344
Griffith, R. Sumter, 891
Groesbeck, Harvey Paterson, 891
Grossman, Morris, 792
Grothaus, Dell Lou, 693
Gubin, Sydney, 1250
Guild, George Prescott, 410

H

Haarlammert, Charles Joseph, 311
Hadley, Murray Nathan, 224
Hale, Robert Eugene, 130
Haley, Clarence Foster, 990
Haley, William Thomas, 990
Hall, Frank Marion, 889
Hall, J. Barnard, 410
Hall, Joel Barnard see Hall, J. Barnard
Halligan, Raymond S., 224
Halliwell, Harry Lippitt, 410
Ham, Coyt, 890
Hamer, Douglas, 410
Hamrick, Russell Shelton, 1345
Hanlon, John Joseph, 792
Hannah, Walter White, 990
Hansen, Harry Beauvoir, 891
Harlan, Lee Collins, 792
Harral, Walter E., 1085
Harrington, Walter Leslie, 791
Harris, Eddie Wyatt, 693
Harris, Farley Wingfield, 130
Harris, L. Marshall, 1157
Harris, Louis Marshall see Harris, L. Marshall
Harris, Max, 891
Harris, Richard Lamar, 990
Harrison, Benjamin Irving, 1250
Harriss, Henry T., 311
Harshman, Martin Luther, 792
Hart, Henry Paxton, 891
Hartmann, Hermann H., 1529
Hartshorne, William Ocellus, 891
Harvey, Edward Regis, 130
Haslam, Jacob Edwin, 70
Haury, Victor Givens, 224
Hayes, Robert Hunter, 692
Haynes, Royal Storrs, 1157
Hays, George Robinson, 891
Hazen, Robert, 130
Heaphy, Lawrence Francis, 693
Hearn, Arthur Joseph, 224
Hedges, Albert Parker, 1529
Hedin, Raymond Freeman, 579
Hegge, Rolv Sigvard, 990
Hennan, Clarence William, 1345
Henry, Ziba Lindley, 131

Herman, Israel, 579
Herndon, Lewis Sidney, 990
Herzog, Gustav G. A., 70
Hill, Charles Lowery, 410
Hill, Edgar Ward Sr., 1085
Hill, Howard Gilman, 1159
Hill, John Ewart, 1529
Hill, William Walter, 410
Hines, Clarence Reynolds, 1345
Hinkley, Jonie Joseph, 1159
Hinsen, Gustave Augustus, 131
Hippensteele, Ralph Owen, 1425
Hodge, William Henry, 1159
Hoeper, George Edward, 891
Holden, John Francis, 579
Holst, John Burton, 311
Holt, George Henry, 1159
Holt, Hiram Allen, 1159
Hope, Hollis Frank, 891
Hope, James Alexander, 224
Hopkins, James A., 1159
Hopwood, George Black, 1345
Horn, Thomas Van, 1250
Horne, Smith Hamill, 410
Horner, John Ira Jr., 1425
Horning, Frank, 1345
Hory, Joseph Stanton, 889
Houck, George Emory, 891
Howard, James Gilbert, 1345
Howard, Willard Samuel, 990
Howell, Henry Amasa, 990
Hoyt, Ralph Wilson, 70
Hudgins, Benjamin Ellis, 693
Hudkins, Ira Nelson, 792
Huey, Thomas Ford, 1345
Huey, Thomas Wang, 131
Hughes, Arranda Alphonso Sr., 1345
Hughes, Reese William, 990
Huie, Jesse Henry, 70
Huzik, David Nathaniel, 409
Hutchison, Jay Leonard, 691
Huth, Lucia C. Hoyer, 224

I

Ingersoll, Olive Grace Perry, 1345
Ingersoll, Robert Stephenson, 792
Ireland, Edwin McCormick, 1345

J

Jackson, Eugene, 1425
Jacobstein, Harry, 224
James, Joseph Charles, 579
Jameson, John Broadus, 1425
Jarmin, Ernest George, 70
Jasper, Henry Clay, 1425
Jay, Charlton, 70
Jenkins, David John, 1529
Jennings, Charles R., 579
Jensen, Ernest Harry, 1529
Johnson, Chase Benjamin, 70
Johnson, Robert Stanislaus, 131
Johnston, Harry Isaac, 792
Johnston, Rufus O., 1159
Jones, Carl Thomas, 131
Jones, David Gordon, 410
Jones, Harold Oakland, 791
Jones, Henry Aaron, 1529
Jones, John Robert, 1345
Jones, Joseph Edward, 693
Jones, Le Roy, 990
Jordan, Elverse Morris, 1345
Jordan, Harry James, 1345
Joynt, Martin John, 792

K

Kadzewick, Joseph William, 1159
Kaine, William Joseph, 1159
Kaiser, Albert David, 310
Kaiser, Harry, 579
Kamerer, Samuel Alden, 990
Kaminstein, Isidor, 579
Kaufman, Albert Ross, 1085
Kaven, Gottlieb Henry, 410
Kelley, Charles Henry, 1159
Kelley, Lawrence Clare, 70
Kellogg, Karl Hugh, 579
Kennedy, George Walter, 496
Kennedy, Kendall Owen, 1159
Kenney, Thomas Hopper, 1345
Kerley, James Hoyt, 311
Kerns, Ira Nelson, 1159
Kerwin, Charles Martin, 410
Ketchian, Aram G., 693
Killips, Thomas Allen, 224
Kime, John Thomas, 1159
King, Edward Daniel, 1157
King, Robert, 311
King, William May, 1159
King-McGill, Cecelia Antonia, 1529
Kinne, Harry Winfield, 70
Kirk, Arthur Albertus, 131
Kirkpatrick, Alva M., 990
Kirkpatrick, Joe Stewart, 693
Kirmse, Alvin, 70
Kissling, Arthur Charles, 693
Kistler, Eugene Monroe, 1159
Kistler, Henry Ray, 891
Kloeppel, Chester Samuel, 693
Klucikowski, Norbert Andrew, 1159
Kobak, Disraeli William, 1345
Kobza, Valerian Vincent, 890
Koch, Otto Wilhelm, 70
Koebig, Walter Christian S., 1250
Kochler, Gottfried, 792
Kohrman, Benjamin Myron, 224
Korkes, Seymour, 1159
Koss, Max, 1345
Kramer, Aaron Sigmund, 311
Krecker, William Henry, 496
Krenzl, Charles Edward, 792
Kruger, Alfred Leon, 1157

L

La Barre, Louis Charles, 410
La Fleur, Virgil Alfred, 410
Lamme, Charles Wilson, 410
Landers, Arthur E., 579
Larsen, Marvem Orville, 311
Latimer, Newton J., 990
Laubetsheimer, George Ashby, 311
Laurence, John Gordon, 1345
Lazarus, David, 1345
Lebenstein, Joseph, 990
Lecky, John D., 411
Lee, Edwin George, 693
Lee, Henry Kay, 1345
Leeds, Arnold, 793
Lehan, James William, 70
Lehmann, Werner, 1425
Leiker, Raymond Joseph, 224
Lerrigo, Charles Henry, 310
Leslie, Samuel Brewster, 411
Lessing, Albert, 1345
Lattenberger, Joseph, 496
Levan, Jacob Kimber, 793
Lever, Haseltine Smith Jr., 1250
Levin, Israel, 411
Levine, Sinclair Simcha, 311
Lewis, Austin Philip, 793
Lewis, Morley Brown, 311
Lewkowicz, Ferdinand Frederick, 311
Liechty, Ernest John, 131
Lilienthal, Joseph Leo Jr., 578
Limburg, J. Irwin Sr., 1425
Limburg, John Irwin Sr., see Limburg, J. Irwin Sr.
Lincoln, Clevero Lee, 990
Lipkind, Max Abraham, 793
Lippold, William Edward, 1425
Livingston, William Herschel, 411
Loewy, Paul, 496
Logan, William H., 693
Lominack, Reyburn Williams, 497
Love, Claude Franklin, 497
Lowe, Cecil Evan, 1425
Lowrie, Thomas Luther, 1425
Lucius, Richard Spurgeon, 579
Lunn, Edwin De Moss, 990
Luse, Raymond J., 224
Lyle, William Gordon, 311
Lyon, Brockton Reynolds, 793

M

McAloose, Joseph Thomas, 793
McCall, Daniel Thompson, 131
McClellan, Robert Hamilton, 497
McCluer, Barton Bates, 1345
McCormick, Bernard John, 497
McCorvie, John Edward, 411
McCroskey, Charles Henry, 70
McDaniel, Guy Lafayette, 497
McDonald, Charles Wesley, 131
McDonald, Joseph John Alexander, 311
McDougall, Clarice Louise, 71
McDowell, William Patton, 991
MacEachern, Malcolm Thomas, 577
McGarrahan, John Francis, 579
McGuigan, Cletus Edmund, 411
McIlwaine, Richard, 891
McKee, Edwin David, 1345
McKee, William, 1529
McKenzie, John Marvin, 1425
McKibben, Clovis Little, 1345
McLain, Andrew Demetrius, 1345
McLaughlin, Alexius Aloysius, 497
MacLean, Sydney Murdoc, 131
MacMillan, Hugh Allan, 693
McNeil, Gordon Charles, 1529
McNish, George Thomas, 497
McNultz, Harry James, 71
McPherson, Warren Gordon, 71
Maddox, Robert Daniel, 131
Maddren, William Harvey, 579
Maertz, William Francis see Maertz, William Frank, 1157
Maha, Frank Joseph, 71
Malick, Clarence Hiram, 411
Mamlok, Hans Walter, 1345
Mandeville, Ernest Arthur, 1345
Mantia, Mario Francis, 991
Marcley, Walter John, 409
Maris, William, 793
Martin, Leonidus Hamilton, 579
Marxer, Barney Joseph, 131
Marxmiller, Harry George, 1345
Maryanski, Joseph Edward, 793
Mason, Frank Ebaugh, 496
Mastin, Orville Charles, 579
Mathias, John Homer, 497
Maxey, Nathaniel Coleman, 131
Mega, Gaetano Thomas, 1529
Meissner, Tom Otto Walter, 130
Melinder, Roy George, 793
Mentzer, Mary Jones, 411
Meyer, Jacob, 791
Meyers, Frederick Carroll, 793
Miles, Lee Monroe, 1424
Miller, Austin Vicente, 991
Miller, Bert Elby, 224
Miller, Charles Scott, 1345
Miller, Eugene A., 497
Miller, George Henry, 311
Miller, Hilma Catherine Louise Swanson, 991
Miller, Samuel, 497
Miller, Sayers John, 793
Mills, Frank Wilbur, 1345
Milton, Benjamin S., 497
Minahan, John James, 991
Mitchell, Michael Loeb, 411
Montgomery, William F., 793
Moody, Joseph Edgar, 793
Moore, William A., 1346
Moore, William Lee, 497
Morin, John B., 1346
Morrall, Samuel A., 1346
Morris, Samuel Archard, 411
Morrison, Gordon Mackay, 496
Morrison, Harry Kavanaugh, 991
Morrissey, Michael Joseph, 497
Morton, Arthur Price, 692
Morvillo, Filippo, 579
Motamed, Hossein, 311
Moul, Charles Thomas, 693
Muhlenberg, Hiester H., 793
Mullen, Vincent Lester, 693
Murrah, Frank Clay, 181
Myers, Edward Morrison, 793

N

Nairn, George Waverly, 793
Neal, Charles Allen, 1346
Neal, Lovell Arthur, 497
Neely, Elmer E., 1425
Nelson, Robert Lyman, 497
Nelson, Siegfried, 1425
Nemens, Harry S., 991
Nesse, Gerhard Martin, 693
Nettles, Thomas Earl, 71
Nexsen, Harold, 991
Niemann, George Henry, 793
Noel, Malcolm Ernest Jr., 411
Nofer, George Peacock, 991
Noordewier, Albert, 497
Northcutt, Joseph Donaphin, 1425
Nutter, Charles Francis, 1159
Nyeum, John William, 497

O

Ochsner, Edward H., 579
O'Connor, Thomas Walter, 1346
Ogilvie, Gordon Daniel, 793
Omelvena, James Gibson, 497
Openshaw, Clarence Roy, 411
Orr, Thomas Gordon, 224
Osburn, Burt Frank, 1346
Ottman, John Carl, 71

P

Paige, Beryl Holmes, 224
Parker, Ashley Stephens, 224
Parker, B. Morgan, 1250
Parkes, Charlotte Bethel, 1159
Partridge, Carroll Dunham, 693
Partridge, Herbert Graves, 411
Pate, Cordy Norford, 71
Patrick, Joseph Franklin, 1159
Patterson, Alpheus Wood, 793
Patterson, Rex Arthur, 1250
Patterson, Willard Albert, 991
Pattison, Charles C., 411
Payne, William Keefer, 891
Peacock, Albert Cicero, 411
Pearis, Ralph Plummer, 497
Pearsh, Norman Raba, 71
Pearce, Claude Clifford, 1250
Peck, Raymond Edward, 224
Penn, Moise, 1346
Pennell, Walter Johnson, 891
Perry, Henry R., 224
Pershing, Edward Hamilton, 411
Peskind, Samuel, 497
Peters, John, 1346
Peters, John Punnett, 889
Petterson, Edward Chester, 1425
Pettit, Joseph A., 790
Petty, Alonzo Allen, 224
Phillips, James Benajah Jr., 991
Phipps, Howard Morton, 991
Pike, Charles Heyfield, 131
Pike, Ernest Reginald, 1346
Poole, William L., 1346
Porter, Thaddeus Glass, 71
Portnoy, Maurice, 1250
Poston, William Onez, 71
Potonky, Henry, 311
Powe, Joseph Leslie, 411
Prager, Bert Ashman, 411
Pratt, William Henry, 497
Presson, Loren Cecil, 411
Preston, Frank, 1159
Price, William Herbert, 1159
Pridmore, George William, 1085
Pruett, Harry Jeroam, 1529
Pyles, Richard Henry, 311
Pyrtle, James Robert, 1159

Q

Quigley, Frederic James, 1159
Quist, Henry William Sr., 411

R

Ragan, Stephen Thomas, 891
Ragins, Oscar Benjamin, 71
Raines, Hugh Robert, 1346
Rains, George Perry, 693
Rasck, Alfred Gregor, 497
Ray, Emmett Boyd, 497
Raymond, Albert Orville, 1528
Redfield, Robert Ray, 1157
Reed, Henry L., 1159
Rees, Amos Gager, 891
Regan, Louis John, 409
Rehberg, Albert Walter, 71
Reibstein, Harry Bennett, 1346
Reincker, George Wiet, 1346
Reusch, George F., 1085
Reznick, Leon, 411
Rice, George Elmer, 1425
Richards, Cyrill Godfrey, 1346
Richardson, Ethyl Harriet, 1250
Richeson, Carrie A., 1085
Richie, Elisha Roberts, 1346
Richman, Samuel Herbert, 1346
Richter, Conrad, 497
Rieg, John Fred, 1159
Rimer, Edward Sherrard, 497
Rinehart, James Fleece, 496
Risk, Robert Alexander, 224
Rissinger, Arthur Joe, 1085
Roberson, Foy, 889
Robison, John Isaac, 411
Rogers, Fred Drake, 1085
Rood, Aaron D., 411
Roper, Joseph Charles, 409
Rose, Fred, 1529
Rosenberg, William A., 71
Rosengard, Benjamin Livingston, 496
Rosenkrans, Harvey R., 131
Ross, Almon Bartlett, 1250
Ross, Edward Harlan, 71
Ross, Pren James, 1250
Ross, Wilbur Wesley, 1346
Rothman, Herman Robert, 497
Rudomin, Joseph, 693
Russell, Frank Hamer, 498
Russell, Franklin Howard, 71
Rutherford, Thomas Arthur, 890
Ruud, Helga Mariane, 891
Ryan, David Charles, 1425

S

Sandler, Morris, 498
Sandstead, Harold Russell, 311
Sankey, Joseph Lee, 224
Sayre, Harry Clinton, 1160
Scadron, Eugene Nestor, 1160
Schein, John E., 693
Schiltz, Frank A., 131
Schmidt, Alfred Richard C., 1250
Schumm, Herman Charles, 692
Schutz, Paul Jeffrey, 1425
Schweigert, Edward A., 498
Schwenkmeyer, George Frederick, 498
Scodel, Benston, 991
Scott, Stanley Lawrence, 411
Season, Edwin Herbert, 1160
Seeley, Ralph Allen, 693
Selberth, Jacob, 498
Selinkoff, J. Jesse, 496
Senkler, George Easton, 1529
Serlen, Murray, 411
Shackelford, John Armstrong, 1425
Shallcross, Joseph Watton, 1085
Shallow, Thomas A., 889
Shanklin, Eldridge Madison, 990
Shapiro, Robert, 498
Shapiro, Max Dee, 71
Shaw, Norman Dudley, 498
Shelley, Hilton J., 1160
Shelton, Norris, 1160
Sherman, Henry Dorr, 1529
Sherrard, Milton B., 498
Shipp, Loring M., 1529
Shivelhood, Elizabeth Kalbach, 498
Shorr, Ephraim, 889
Shuman, Paul Anderson, 1346
Siegel, Charles Wulf, 498
Silverberg, Minor D., 1346
Simmons, Sterling Price, 1529
Simon, Emil Robert, 991
Simpson, Clarence Eugene, 498
Simpson, Nathaniel Norvin, 1346
Sims, Leslie Bennet, 1425
Sine, Arnot Crawford, 1160
Skaggs, D. Randolph, 991
Slavin, Joseph Edward, 1160
Smedley, Charles William, 991
Smith, Charles Gordon, 1529
Smith, Edward Michael, 991
Smith, Fredrick Donald, 71

Smith, George Herbert, 891
Smith, Henry Louis, 693
Smith, John Charles, 793
Smith, John Jay Hamilton, 71
Smith, John Max, 1346
Smith, Phillip Dudley, 693
Smith, William Hamilton, 71
Smoczynski, Mieczyslaw Edward, 1160
Snavely, Marion Elizabeth, 498
Snow, Morton McCulloch, 793
Snow, Walter Rozelle, 793
Sommerfield, William Ansel, 991
Sorrells, John Ennis, 1160
Spencer, F. Erle, 71
Spencer, Ira Thorp, 71
Spiceland, Jack Logan, 498
Spieth, William Henry, 71
Staats, Okey Maxwell, 1160
Stacy, George Herbert, 1529
Stallings, Russell Duke, 498
Stammer, Emanuel Louis, 991
Stanchfield, Harve Avery, 1346
Standifer, Lilburn Echols, 693
Stegall, Robert Edward, 1529
Stein, Clarence Cornelius, 693
Stein, Robert, 993
Steinlein, Oscar W., 1529
Stephens, Virgil Ray, 131
Stern, Jacob, 498
Stevenson, Ellerslie Wallace, 498
Stine, Ira Allen, 793
Stokes, Henry Archer, 1346
Stone, Emil Herman, 498
Storck, Edward Hugo, 793
Storms, Harold Ackerman, 1529
Stoudenmire, Dennis Carnegie, 411
Stough, William Vesta, 991
Stratton, Ralph Rieker, 498
Strauss, Alvin Weil, 498
Streicher, Michael Henry, 1425
Strieder, Hugo John, 793
Strom, Adrian Donovan, 793
Stroupe, Henry Van Hoozer, 1250
Stuart, Daniel Delehanty Vincent Jr., 498
Suffoletta, Daniel Benedict, 1160
Sullivan, Gerald Joseph, 1250
Sullivan, William Terrence, 1346
Sutton, Edward Forrester Holden, 131
Swartley, William Blaine, 409
Sykes, George Frederick, 498

T

Tankersley, William, 498
Tatum, Arthur Lawrie, 693
Taylor, Hermon Marshall, 69
Taylor, William Ray, 1160
Tesar, Frank Joseph, 991
Tewksbury, William Davis, 1424
Thabes, John Abeis Jr., 131
Tharp, Roger Allen, 498
Thompson, Jay Ira, 411
Thompson, Mary Fowler, 1250
Thompson, Peter Hunter, 498
Thompson, Samuel Evans, 890
Tidmore, Thomas Lee, 1529
Tinker, Charles Lawrence, 1250
Tobey, Harold Grant, 889
Tompkins, Charles Ernest, 991
Tredway, Thomas Palmer, 793
Treharne, Frank Edwin, 1529
Trewhella, Arthur Paul, 498
Trinder, John Holmes, 498
Triolo, Antony, 409
Tripodi, Donald William, 71
Tritsch, John Edgar, 1160
Truitt, Crawford Sylvanus, 991
Turrill, Vernon Le Verne, 1160

U

Updegraff, Chester Deric, 131
Upham, Roy, 889
Ursprung, Charles William, 411
Uzzell, Edward Foy, 1160

V

Vander Veer, Frank Leroy, 131
Van Nuys, Walter Crowe, 498
Van Sickle, Walter Joy, 498
Vidrine, Arthur, 889
Vogt, Walter Eugene Jr., 1160
Vohr, Dorothy Ruth Larrison, 1160
Voss, Norwood Warner, 1250
Vrooman, Earle Morey, 889

W

Walker, Arthur Mecker, 998
Walker, Elijah Alexander, 579
Wallace, Harry M., 991
Wallach, Isidor Arthur, 991
Wallis, James R., 71
Walshe, Joseph Aloysius, 1250
Walters, Arthur Edward, 991
Walton, Lief Elmer, 1346
Wardleigh, Claude Ernest, 793
Ware, Ford, 131
Ware, John Sayers, 791
Waters, Charles Millard, 498
Waters, James M., 1065
Webb, Frederick Leon, 991
Webb, Harold Randall, 579
Webb, Robert Marvin, 1425
Webb, William C., 1160
Webbe, Robert St. Clare Stanley, 411
Weber, Bernard Aloysius, 1250
Weeks, Joshua Herbert, 891
Wehr, Charles Jesse, 1346
Weexcat, Absalom Steelman, 71
West, Richard Thomas, 131
Westmoreland, James Paschal, 311
Wharton, Choyd Franks, 579
Wheeler, Alonzo Marsh, 224
Whelchel, Troy Cooper, 131
Whitacre, Rolland John, 1343
White, Charles Alexander, 991
White, Paul Amos, 1160
White, Stanley Ray, 1250
White, Thomas Wistar, 1346
Wick, Victor V., 1160
Wicks, Orlando Curtis, 1085
Williams, Mary Edith, 1529
Williamson, Cordelia Isabella Mac-Naughton, 1160
Wills, Thomas Opie, 991
Wilson, Charles Wesley, 579
Wilson, Hermon Fowler, 131
Wilson, Ida May, 579
Wilson, Willets, 1425
Winkelman, Nathaniel William, 1343
Winning, Charles Crain, 1529
Winters, Walter Payne, 1425
Winter, James Wilson, 411
Witepalek, William Wencel, 1160
Witt, Carl Brent, 991
Wolfe, Howard Hartnette, 311
Wollner, Henry, 311
Wood, Will Lee, 224
Woodall, George Hogan, 71
Woods, John Olen, 1346
Worster, William Willis, 71
Wright, Floyd Reddicks, 224
Wulp, George Adolf, 1160
Wurmfeld, Armin, 1085
Wycislik, John Parma, 1160

Y

Yoder, Anna Beatrice Blattenberg, 1085
Yost, Nellie Maude, 71
Young, Evelyn Nancy, 1160
Young, Franklin Charles, 71

Z

Zehnder, Anthony Charles, 579
Zepp, Herbert Elmo, 693
Zickind, James Allen, 793
Zook, Joseph Allen, 411

EDTA: See Edathamil

EAR
disease (chronic), middle and attic: surgery to preserve hearing, [Ducrs] *451
drum perforation closed, [Pang] 719—ab
drum perforation with suppuration, treatment during respiratory infection, 817
infections, medical treatment, [Davison] *105
transtympanic stapes mobilization for oto-sclerotic deafness, [Kos] 1436—ab

EASTER Seal Campaign opens, 786

EBERTHELLA
typhosa, surgical removal of foci in carriers, [Anders] 325—ab

ECLAMPSIA
conquest of, [Falls] *251; (low sodium diet in control) [Allen] 997—C
preeclampsia and, acid-ophthalazine derivatives for, [Cesaretta] 82—ab

ECONOMICS
poliomyelitis in community of high socio-economic level, [Nolan] 512—ab
socioeconomic distribution of lung cancer in New Haven, [Cohart] 722—ab

ECONOMICS, MEDICAL
ambulance costs in N.H.S., United Kingdom, 1429
drug prescribing problems, Ministry of Health's bulletin on, England, 314
drug prescribing, regional cost variations, United Kingdom, 1256
drug samples, problems of prescribing in rural areas, United Kingdom, 1167
drugs, cost for private patients, United Kingdom, 701
drugs, definitions, United Kingdom, 1167
Guillebaud report of N.H.S. costs, United Kingdom, 996
hospital costs inquiry by British Parliament, 798
hospital room rules survey by American Hospital Ass'n, 573
let's save university training hospitals, [Cutler] *282

ECZEMA
premenstrual, in woman 24, treatment, 341; (reply) [Greenblatt] 1186
varicose, generalized, [Hasthausen] 603—ab

EDATHAMIL
to remove metastatic calcium deposits affects blood and urine calcium tests, [Carr & Frank] 1258—C

EDATHAMIL CALCIUM-DISODIUM
dimercaprol with, to mobilize copper in hepatolenticular degeneration, United Kingdom, 1353
effect on lead in blood and urine of battery workers, [Manzille] 86—ab
toxicity, nephrosis, [Foreman & others] *1042

EDEMA
improves after malaria for nephrotic syndrome, [Gilbertsen & Basbour] *25
in heart insufficiency, Dr. Luckey of Cornell U. lectures in Chile, 796

EDEMA—Continued
macular, with retinitis: heredomacular degeneration vs. central serous retinopathy, (reply) [Gordon] 610
of the newborn, **ACTH** for, [Nuñez] 1177—ab

EDROPHONIUM CHLORIDE
to diagnose myasthenia gravis, [Osserman & Teng] *153

EDUCATION
health implications of White House conference, 120—E
public, county medical society activities, [Council article] *564

EDUCATION, MEDICAL
American Medical Education Foundation: See Foundations
Annual Congress (52nd), (program) 54; 120—E; (report) 978
basic sciences in, Annual Congress discusses, 979
by accretion or by design for specialists? [Comroe] *1323
Financial Support: See Schools, Medical
graduate, report of Annual Congress, 979
let's save university training hospitals, [Cutler] *282
Medical Council of India discusses, 797
postgraduate program, [Warner & Bowers] *1306
postgraduate, income tax deduction of expenses, [Medicine and the Law] *299
recommendations for Indian conference, 695
reintegration of medicine, 1472—E
research interrelationship, [Shannon] *1029
value of autopsy, guest editorial by Dr. Starr, 1144—E
week, A.M.A. cosponsors, [Public Relations] *59; (significance) 1410—E

EGGS
blood media compared for Mycobacterium tuberculosis isolation, [Dunlop] 695—ab
Chinese, food poisoning from, England, 227
let's save the goose with golden eggs: university training hospitals, [Cutler] *282

EGO
disintegration in aged, etiology, [Busse] 242—ab

EINSTEIN College of Medicine: See Albert Einstein

EISENHOWER, DWIGHT DAVID
advisability of second term, A.M.A., opposes answering questionnaire, 52—E
A.M.A. Board of Trustees commends health program, 678
coronary thrombosis in, request information on other patients with, [White] 159:1148, Nov. 12, 1955
encourages Joint Blood Council, 981
recommends government aid increase for research, [Davidsohn] 1091—C

EISENMENGER COMPLEX
4 cases, [Espino-Vela] 1094—ab

ELBOW
fractures, inserts for, Austria, 1426
function after dislocation of radius head in children, [Stelling & Cote] *782

ELECTRIC
burn, death 63 days later, after skin transplants, Austria, 132
current diagnosis of neuromuscular disease, (reply) [Licht] 76—C
shock effect on nerves: perform sympathectomy by this means? 817
shock therapy, danger of combining with rauwolfia and chlorpromazine, (reply) [Epstein] 503—C
shock therapy, non-specific effects, [Marley] 889—ab
shock therapy, peroneal paralysis after, [Kartliner] 586—C
shock therapy, voltage and amperage: frequency of use; ill-effects, 339

ELECTRICITY
conductive floor problems in hospitals, 1099
wired and static, explosion hazard during anesthesia from, [Cole] 135—C; (reply) [Van Atta] 703—C

ELECTROCARDIOGRAM: See Heart

ELECTROCORTINE, See Aldosterone

ELECTROENCEPHALOGRAPHY, See Brain

ELECTROKYMOGRAPHY: See Heart

ELECTROLYTES
blood loss and transfusion effect on metabolism of, after trauma [Fleur] 419—ab
imbalance and diarrhea with heart disease and rectum cancer, (diagnostic Problems) [Frazier] *774; (comment) [Bay] *775

ELECTRON Microscopy: See Microscopy

ELECTRONICS
apparatus to measure therapy in paralysis agitans, [Agate & others] *852

ELIZABETH II, Queen of Great Britain
visits veterinary school, 228

ELORINE: See Tricyclamol

EMBOLISM
air, after antral lavage, [Thomson] 719—ab
anticoagulants to prevent, in mitral stenosis, [Varela de Seijas Aguilar] 591—ab
fat, after abdominal surgery, [Schofield] 1368—ab
fat, of retina after trauma, [Kearns] 1370—ab
pulmonary, fatal after abdominal surgery in old age, [Gilchrist & de Peyster] *1373
pulmonary, in genitourinary surgery, [Mathé] 917—ab
treatment, [Olwin] *1101
tumor emboli in thoracic duct, pathogenesis of Virchow's node, [Zeidman] 721—ab

EMERGENCY
bed service, United Kingdom, 1167
call plans inaugurated, Conn., 301
calls, dial "DOC" proposed, United Kingdom, 502
handling of frozen foods, [Hozier] 149—ab
surgery risk in old age, safeguards, [Gilchrist & de Peyster] *1373
treatment of bleeding esophageal varices, [Linton & Ellis] *1017

EMERSON HAND BELLOWS for respiration by uncuffed tracheostomy tube, [Mörch & others] *864

EMETINE
treatment of amebiasis, (United Kingdom) 996; (current status) (Council report) *1250
treatment of traumatic liver abscess, India, 992
EMOTIONS
disorders, chlorpromazine and reserpine for, [Zeller & others] *179
disorders, stuttering from, guest editorial by Dr. Blanton, 1472—E
EMPHYSEMA
bullous, surgery for, [Walkup] 909—ab
of face, neck, and thorax, from facial fractures, [Heslop] 240—ab
pulmonary, bronchodilators with intermittent positive-pressure breathing for [Leslie & others] *1125
pulmonary (chronic), isoproterenol as adjunct in, S.N.R., 59
pulmonary, complicating tuberculosis; surgery for, [Newman] 1367—ab
pulmonary, relation to dust exposure, (reply to Dr. Sander) [Mayer & others] 230—C
EMPLOYEES: Employment: See Industrial Health
EMPYEMA
staphylococcal, [Brownrigg] 328—ab
ENCEPHALITIS
chronic, can cause uncontrollable rage, 520
endemic primary, Italy, 895
postvaccinal, rare, France, 1350
ENCEPHALOMYELITIS
treatment, zoxazolamine, [Rodriguez-Gomez & others] *752
ENCEPHALOPATHY
infantile, cerebral hemispherectomy for, [Ferey] 1535—ab
ENDAMOEBA
histolytica, incidence of carriers; arsthinol for, [Brown & others] *360; 395—E
ENDARTERITIS
aneurysmal, after resection for aortic coarctation, [Martin & others] *871
ENDOCARDITIS
bacterial, neomycin for; fatal nephropathy after, [Powell & Hooker] *557
bacterial, subacute, early diagnosis, [Wedgwood] 321—ab
bacterial, subacute, healed: outlook for, [Mendelson & others] *437
bacterial, subacute, penicillin V for, [Quinn & others] *951
bacterial, subacute, treat for, after rheumatic fever history and fever? 609
bacterial, subacute, treatment, [Henriksen] 882—ab
staphylococcal, after mitral valvulotomy, [Dalton] 1366—ab
ENDOCARDIUM
fibroelastosis, infantile and childhood type, [Dimond] 83—ab
ENDOCRINE GLANDS
function, stains for cervical and vaginal study of, 726
nutrition and, [Salvesen] 322—ab
ENDOMETRIOSIS
intraperitoneal, [Ramse] 715—ab
of pleura, incidence, 1185
on laparotomy scar 10 years later, [Fernandez-Ruiz] 1266—ab
ENDOSCOPY
hexylcaine topical anesthesia, [Orkin & Rovenstine] *1465
ENERGY
expended during rest, United Kingdom, 1532
ENTERAMINE: See 5-Hydroxytryptamine
ENTERITIS: ENTEROCOLITIS: See Intestines, inflammation
ENTEROBIASIS: See Oxyuriasis
ENURESIS: See Urine, incontinence
ENZYMES
in meat tenderizer harmful? 1004
of liver in protein malnutrition, India, 796
EOSINOPHILS
blood histamine in eosinophilia, India, 893
lungs infiltration with, during isoniazid treatment, [Perreau] 147—ab
tropical eosinophilia, arsenic for, India, 696; 992
EPENDYNOMA
infiltrating, of brain, India, 895
EPICARDIUM: See Pericardium
EPIDEMIOLOGY
approach to etiology of larynx cancer, [Wynder & others] *1384
physicians and public health departments in, [Pinckney] *1450
EPILEPSY
diagnosis and treatment, Peru, 75
employment, conditions for epileptic schoolteachers, England, 74
epileptic drivers, United Kingdom, 996
prognosis, insurance mortality study, [Bolt & Lew] *736
psychomotor, sexuality in, France, 580
special service for, urged, Denmark, 412
surgical treatment, [Titrud] 242—ab; [Weber] 420—ab
treatment, acetazolamide, [Lombroso & others] *203
EPILEPSY—Continued
treatment, diphenylhydantoin sodium, [Murphy & Schwab] *285
treatment, Nuvarone; fatal aplastic anemia after, [Isaacson & others] *1311
treatment, Phelantin, [Davidson & Berman] *766
EPINEPHRINE
plus tetracaine in anterior stellate ganglion block [Moore & Bridenbaugh] *158
EPSTEIN, BRUNO
intern at Cook County Hospital killed in line of duty, 1148
EQUANIL: See Meprobamate
ERUCTATION
chest pain relieved by drinking water and, Diagnosis? 1099
ERUPTIONS
generalized, in varicose eczemas, [Haxthausen] 663—ab
Industrial: See Industrial Dermatoses
ERYTHEMA
streptogenes could cause facial depigmentation, 340
ERYTHREMIA: See Polycythemia
ERYTHROBLASTOSIS, FETAL: See Hemolytic Disease of Fetus and Newborn
ERYTHROCIN: See Erythromycin
ERYTHROCYTES
aggregation and alcohol intake, [Forsander] 815—ab
antibody-coated in ulcerative colitis, [Lorber] 594—ab
Cr^{51}-labelled, to measure blood volume, [Walser & others] *858; [Meyer] *1312
morphology in tumor presence, [Korinth] 245—ab
thromboplastin formation relation to, [de Vries] 337—ab
ERYTHRODERMA
exfoliative, CB 1348 for, [Galton] 331—ab
ERYTHROMYCIN
treatment of amebiasis, [Jung] 1096—ab
treatment of scarlet fever, compared to spiramycin, [Martin] 603—ab
ERYTHROPOIESIS: See Erythrocytes
ESCHERICHIA
coli infection in the newborn, Brazil, 313
ESIDRONE
treatment of cirrhosis, Peru, 134
ESOMID: See Hexamethonium
ESOPHAGUS
digestive pathology, [Peters] 1178—ab
hiatus hernia, and cardiospasm, [Boyd] 320—ab
peptic, [Wolf] 706—ab
ESOPHAGUS
[Hodges] 605—ab
achalasia, surgery for, [Sweet] 1174—ab
alkali burns, management, [Carver & others] *1447
cancer etiology, [Mosbech] 1173—ab
cancer, resection with Berman polyethylene prosthesis for, Austria, 1251
cancer, surgery for, Switzerland, 316
dilatation, question of cardiospasm with, (reply) [Vinson] 703—C
erosions, hydrocortisone-ids for, Austria, 1426
gastric junction, hiatal hernia and related disorders, [Texter & others] *830
peptic ulcer and esophagitis, and marginal ulceration in, [Wolf] 706—ab
pneumoperitoneum to differentiate hiatus hernia from angina pectoris, [Maisel & Horger] *868
ring, lower, [Schatzki] 1179—ab
rupture, spontaneous, [Swann] 324—ab
stenosis, fluid in upper mediastinum from, [Catalano & Levin] 1533—C
ulcer, regurgitant, [Schmidt] 237—ab
varices (bleeding), diagnosis and management [Berkowitz & others] *1398
varices (bleeding), emergency treatment, [Linton & Ellis] *1017
web, lower, [Ruggles] 886—ab
ESPRESSO COFFEE DISPENSERS
wrist complication in operators, United Kingdom, 1532
ESTROGENS: See also Diethylstilbestrol
effect on serum histaminolysis, [Quaini] 1369—ab
treatment of prostrate cancer, [Ganem] 916—ab
viscera hemorrhages in hyperfolliculinism, [Klotz] 144—ab
ETAMON: See Tetraethylammonium Chloride
ETHER Anesthesia: See Anesthesia
ETHICS, MEDICAL
British Medical Ass'n. examines physician anonymity on the air, 1531
Dr. Kelvin charged for associating with Akers' Clinics and baldness cures, United Kingdom, 897
fee splitting, President Hess' page discusses, 675
international congress (first) discusses drug clinical testing, 695
problem in newspaper medical coverage, [Wilmer] *768
ETHINAMATE
S.N.R., 289
ETHOPROPAZINE HYDROCHLORIDE
treatment of paralysis agitans, [Doshay & others] *348; (quantitative measurement of results) [Agate & others] *352
ETHYL CARBAMATE: See Urethan
ETHYL IODOPHENYLUNDECYLATE
myelography in leg pain from thoracic and cervical cord tumors, [Scott] *528
myelography, pitfalls, [MacCarty] 335—ab
ETHYLENEDIAMINE-TETRAACETIC ACID: See Edathamil
EUNOCTAL: See Amobarbital
EUPHORIA
problems, barbituric acid abuse, [Myschetzky] 1176—ab
EVACUATION
of Vietnamese, Lt. Dooley to lecture, 576
USPHS responsibilities in civil defense, [Hozier] *1206; [Christensen] *1209
EVIPAN: See Hexobarbital
EXECUTION: See Capital Punishment
EXERCISE
dynamic, for elderly amputee, [Elsert] 1266—ab
for ataxia of arm, hand, and foot after brain operation, 1185
tennis contraindicated 3 years after coronary insufficiency in physician 39? 342
therapeutic, for rheumatoid arthritis, [Rae & Bender] *611
EXHIBITS: See also Art
of Freud memorabilia, N. Y., 62
pictorial, of Presidential physicians, D. C., 215
EXOCRINE GLANDS
fibrocystic pancreas as generalized disease of, (di Sant' Agnese) *816
EXOPHTHALMOS
postoperative malignant, triiodothyronine for, [Frawley & others] *646
thyroid disease with, visual defects in, [Hedges] 604—ab
EXPLOSIONS: See also Atomic Bomb
air conditioner for operating room, (reply) [Walter] 152
hazard in anesthesia from static and wired electricity, [Cole] 135—C; (reply) [Van Atta] 703—C
hazard of strobelights in operating rooms? 816
EXTREMITIES: See also Arms; Fingers; Foot; Hand; Legs
fractures with gangrene in old age, [Miller] 598—ab
EYEBROWS
shaving prevent their regrowth? 816
EYEGLASSES: See Glasses
EYELIDS
forceps for ptosis operation, [Berens] *207
EYES
damage by tobacco, [Hedges] 604—ab
diseases, sleep therapy in, France, 1428
first eye bank in Iowa, at State U., 301
protecting workers and those nearby in welding, 424
refraction, crossed cylinder in, value, 1183
tension, Berens-Tolman indicator evaluated, [Cholst & Horovitz] *661
EYESIGHT: See Vision

F

FABRICS: See Textiles
FACE
bone fractures in, emphysema of face, neck and thorax after, [Heslop] 240—ab
depigmentation not due to fungi, possibly vitiligo or erythema streptogenes, 340
FACIAL TISSUES: See Tissues (paper)
FAINTING: See Syncope
FAITH
healer, 292—E
in medicine, [Blanton] 1355—C
FALLOPIAN TUBES: See Oviducts
FAMILIES: See also Heredity; Twins
colon polyposis, osteomatosis and soft-tissue tumors: familial syndrome, [Weiner] 142—ab
familial dysautonomia, [Harris] 811—ab
familial xanthomatosis with hypercholesteremia, Denmark, 412; [Piper] 594—ab
family planning, United Kingdom, 1430
health record, Connecticut physicians distribute, [Public Relations] *860
help service, recommends continuing, England, 73
hypertension in 3 generations, United Kingdom, 1256
hypertrophic pyloric stenosis in parent and child, [McKeown] 916—ab
multiple sclerosis in, [Estborn] 998—ab
neonatal hepatitis in siblings, [Krainin & Lapan] *937
splenectomy for familial lupus erythematosus, [Cardoso] 321—ab
susceptibility to poliomyelitis? 1004
thyroid adenoma genesis in siblings, [Zondek] 1260—ab
FANCONI'S Anemia; Syndrome: See Anemia, aplastic

FAT
absorption, British gastroenterologists discuss, 313
biophysical basis of physical medicine, [Schwan] *191
deposits on legs, diagnosis; treatment, 1184
embolism after abdominal surgery, [Schofield] 1368—ab
embolism of retina after trauma, [Kearns] 1370—ab
fatty liver cirrhosis, lipotropic agents in pathogenesis and treatment, (Council article) [Gabuzda] *969
infiltration of parotid gland simulating tumor, [Gilman & others] *18
FATIGUE
ulnar fractures during, [Evans] 913—ab
FEAR
of needles in otherwise normal woman, 1100
FECES
examined to detect typhoid carriers, (reply) [Enright] 342
examined to diagnose amebiasis, [Brown & others] *360; 393—E
hospital staphylococcus carrier state, [Brodie] 901—ab
poliomyelitis virus excretion after oral immunization, [Skopowski & others] *954
Shigella survival in sewage [Wang] 1371—ab
FEDERAL: See also United States
Bureau of Investigation seeks identity of man treated for x-shaped wound on face, 215
Income Tax: See Tax
Legislation: See Laws and Legislation, federal
FEES
fee splitting, President Hess' page, 675
for home consultations by specialists in N.H.S., England, 227
FEINBERG, A. R., and FEINBERG, S. M., guest editorial: allergy to penicillin, 778—E
FELIX, ARTHUR (1887-1956)
died in London, 898
FELLOWSHIP FOR FREEDOM IN MEDICINE
annual meeting discusses N.H.S., heroin manufacture, and physician supply, England, 226
FELLOWSHIPS
American Academy of Dermatology and Syphilology, 305
American Cancer Society, 1339
approved by A.M.A., by specialties, 159:251, Sept. 24, 1955; (supplementary list and corrections) 160:212, Jan. 21, 1956
in allergy at Northwestern, 488
in biometry and epidemiology at Yale, 880
in cancer chemotherapy at Stanford, 300
in cardiology, St. Michael's Hospital, Newark, 217
in cardiovascular pathology at Mt. Sinai Hospital of Greater Miami, 301
in child psychiatry, 3rd postgraduate year, 505
in hospital administration at Cornell, 881
in neurology, grant to Georgetown U. for, 301
in pediatric cardiology, at Children's Orthopedic Hospital, Wash., 404
in pediatrics at Ohio State U., 685
Kovacs (Richard), for International Congress of Physical Medicine, 491
Lilly (Eli) Medical Research (South Africa), [Shapiro] 587—C
National Council to Combat Blindness, in ophthalmology, 1060
National Foundation for Infantile Paralysis, (in orthopedic surgery) 219; (for state health educators) 491
Oak Ridge Institute of Nuclear Studies, 65
Wilder (Russell M.), by National Vitamin Foundation, 303
FEMUR
fracture, minimum hospitalization after pinning, 88
fracture, traction for children, [Stryker] *288
osteochondrosis of capital epiphysis, Thomas splint for, Austria, 794
FERTILITY: See also Sterility
after cryohypexy for cryptorchism, [Gross & Jewett] *634
altitude effects on, Peru, 134
World Congress (2nd), Italy, May, 1956, 66
FETUS
aspiration syndrome and hyaline membrane, x-ray patterns, [Pettersen] 148—ab
presentation, prolapse of arm in, Austria, 1347
FEVER
after triple vaccine, 1004
chills with, why use heat? 608
epidemic hemorrhagic, Korean type in Europe, [Mayer] 510—ab
in post-myocardial-infarction syndrome, [Dressler] *1379
treatment in children, N-acetyl-*p*-aminophenol, [Cornely & Ritter] *1219
FIBRINOGEN
depletion, postpartum hemorrhage from, [Klein] 714—ab
in blood in hemorrhagic diathesis with prostate cancer, [Prout & others] *840
FIBROELASTOSIS: See Endocardium
FIBROMA
renal, India, 75
simulating bone tumors, [Collins & Collins] *431
FIBROSITIS: See Myositis, rheumatoid
FICUS
officinalis latex for thromboses, [Augusto] 333—ab
FILARIASIS
528 cases, India, 796
FINGERS
pigmented villonodular synovitis in; amputate or excise tumor? 424
wrong finger amputated, patient awarded damages, United Kingdom, 701
FINSTERER, HANS, death of, Vienna, Nov., 499
FISTULA
bronchoesophageal, from broncholithiasis, [Davis & others] *535
cholecystogastric, [Melamed & Parker] *463
FIZRIM: See Acetylsalicylic Acid, effervescent
FLAJANI-BASEDOW'S DISEASE: See Goiter, Toxic
FLATULENCE
from diverticula of jejunum and duodenum? 520
FLAXEDIL: See Gallamine Triethiodide
FLEAS
of rabbit, myxomatosis from, United Kingdom, 1253
FLEXIN: See Zoxazolamine
FLOORING
conductive, in hospitals, problems, 1099
FLUIDS
body, in hypertension and mild heart failure, [Walser & others] *858
intravenous, postoperatively, Brazil 225
level in upper mediastinum from esophageal stenosis, [Catalano & Levin] 1533—C
FLUORESCENT
hair from fungi in children, Wood's glass to detect, 124
FLUORINE
Fluoridation of Water: See Water
fluorosis (crippling) compared to rheumatoid spondylitis, [Steinberg] 1371—ab
FLUOROCORTISOL
effects on skin homotransplants, N. Z., 229
FOG
London, and chest complaints, 585
FOLIC ACID
antagonists, status in leukemia, (Council report) *1228
FONTANEL: See Cranial Suture
FOOD
allergy, perennial nasal, [Derlacki] 1436—ab
artificial sweeteners, (Council statement) *875
canned, safety after long storage, 250
coloring matters in, recommendations on use of, United Kingdom, 585
copper in, limits, United Kingdom, 1166
FDA approves chlortetracycline, food preservative, 779—E
FDA warning on Boxsey cancer treatment, 1423
frozen, emergency handling, [Hozier] 149—ab
hygiene laws, United Kingdom, 700
Infant's: See Infants, feeding
intake relation to blood levels from oral penicillins G and V, [Jones] 85—ab
poisoning, bacterially microcoecic and salmonellosis, 291—E
poisoning from Chinese eggs, England, 227
poisoning from milk powder, United Kingdom, 1430
poisoning increased, United Kingdom, 501
poisoning, treatment of typhoid carrier after, 518
preservative, chlortetracycline; **FDA** approved, 779—E
standards for vitamin C, (Council report) *1471
FOOT
Athlete's: See Dermatophytosis
fibrosis, hydrocortisone for, [Zacharias] 421—ab
flat, cause of pigeon-toed walk; use Denis Browne splints, (reply) [Starr] 90
rheumatoid disease, Finland, 892
stretch socks for children, possible harm, [Harell] 897—C
FORCEPS
artery, left in abdomen; removed 5 days after, Sweden, 413
muscle, for ptosis and superior oblique surgery, [Berens] *207
FOREIGN BODIES
artery forceps left in abdomen, removed 5 days after, Sweden, 413
bean in peritoneal cavity after vaginal insertion, United Kingdom, 1353
retained surgical sponges, x-ray diagnosis, (reply) [Grunstein] 891—C
FOREIGN COUNTRIES
liability insurance in, A.M.A. study, 393—E; [Medicine and the Law] *1395
FORMALDEHYDE
urea resin in facial tissues, allergy to, [Peck & Pallit] *1226
FOUNDATIONS
American Foundation for Allergic Diseases program, 1152
American Korean, instruct on shipping medical books for Korea, 372
FOUNDATIONS—Continued
American Medical Education, encourages physician contributions, President Hess' page, 1146
American Research, questionnaire on Eisenhower running for 2nd term, A.M.A. opposes answering, 52—E
Arthritis and Rheumatism, (research grants) 880; (Illinois chapter offices) 1336
Billings (Frank), McArthur Lecture, 1336
Boyer (S. H., Sr.) and Nelson (R. L.) memorial fund established, Minn., 983
Caspary (Alfred H. and Margaret M.) gift to surgical hospital, N. Y., 303
Commonwealth Fund supports medical education, 210—E
Finney (John M. T.) Fund Lecture, 1523
Ford, supports medical education, 210—E
Foundation for Economic Education, address on social security by president, [Public Relations] *185
Friedenwald (Jonas S.) memorial fund in ophthalmology established, 687
Hartford (John A.), arteriosclerosis grants for Harvard U., 216
Horder (Lord) memorial proposed, United Kingdom, 1089
Kellogg (W. K.) grant to U. of Utah for postgraduate medical education, [Warner & Bowers] *1306
Mackie (Thomas T.) memorial fund established, 303
Nalle Clinic, Lectures, 1337
National Foundation for Infantile Paralysis fellowships, (in orthopedics) 219; (for state health educators) 491
National Fund for Medical Education originated Medical Education Week, 1410—E
National Science, grants, 1342
National Vitamin Foundation fellowship: R. M. Wilder, Ohio, 303
Nuffield, (grants for medical research) 584; (to study retirement age) 798
Phi Delta Epsilon, Kaplan Lectureship, 1241; 1523
Rockefeller, research grants for protein study, England, 227
Rosenthal (Richard and Hinda), award for cancer research, 784
Scripps, study children of college graduates, 65
Sears-Roebuck, guide on building medical unit, [Business Practice] *233; *319; *504; *589; *980; *1356
Sears-Roebuck, loans for 10 medical units, 980
Tommy Memorial Fund grant to Yale for leukemia research, 122
Wood (Leonard) Memorial for Eradication of Leprosy elects chairman, 1156
FRACTURES
healing, diathermy effects on, 818
Monteggia, [Mohler] 142—ab
nitrous oxide-thiopental anesthesia for reduction? 518
of elbow, inserts for, Austria, 1426
of external humeral condyle, [Milch] *641
of extremities, gangrene after, in old age, [Miller] 598—ab
of face bones: emphysema of face, neck and thorax after, [Heslop] 240—ab
of femurs, traction for children, [Stryker] *288
of hip, minimum hospitalization after pinning, 88
of radius, typical, [Lidström] 597—ab
of ribs, alleged neglect reported to liability committee, Sweden, 413
of ulna during fatigue, [Evans] 913—ab
propose colored casts for children, [Karbelnig] 587—C
pyridoxine in anesthesia for ambulatory patients with, Peru, 134
treatment, leaving feet skin traction, [Anderson & Robbins] *1315
FRANKLIN, BENJAMIN (1706-1790)
Franklin Institute celebrates 250th anniversary of birth, 65
FREDERICK, GEORGE W., imposter using Dr. C. A. White's name to obtain drugs, 687
FREUD, SIGMUND (1856-1939)
commemoration of birth, N. Y., 1337
memorabilia exhibit, N. Y., 63
FROSTBITE
trauma of, France, 1349
FRUCTOSE
vs. glucose in postinfusion hypoglycemia, 876—E
FRUIT
hydrochloric acid remove poisonous insecticides? 609
FULBRIGHT AWARDS
lecturing and research, in India available, 491
FUMAGILLIN
treatment of amebiasis, [Jung] 1096—ab
FUMIDIL: See Fumagillin
FUNDS: See Foundations
FUNGI: See Mycology
Infection: See Blastomycosis; Coccidioidomycosis; Dermatophytosis; Mycosis; Onychomycosis
FURACIN: See Nitrofurazone
FURADANTIN: See Nitrofurantoin

G

GALACTOSEMIA: See Blood
GALLAMINE TRIETHIODIDE
tests and standards, 1051
GALLBLADDER
calculi in Negro and white races, [Cunningham] 813—ab
calculi in Saint's triad, surgery for, [Palmer] 241—ab
calculi in stomach from fistula, [Melamed & Parker] *463
cancer [Jesseph] 711—ab
disorders, prognosis, insurance mortality study, [Holt & Lee] *736
excision, dyskinesia after, from pancreatitis, sphincteritis, and choledocholithiasis, [Walters] *423
excision in coronary disease, [Keys] 712—ab
excision, intravenous cholangiogram after, [Wise & O'Brien] *819
excision with sphincterotomy for recurrent pancreatitis, [Doubilet & Mollholland] *321
pain over, after automobile accident, 1185
GAMMA GLOBULIN: See Globulin
GANGLION (nerve)
block for severe hypertension, [Bauer] 418—ab; (lung edema and fibrosis after) [Viersma] 505—ab
block (stellate), anterior approach, [Moore & Bridenbaugh] *158
block (sympathetic) for arteritis, France, 1163
block (sympathetic) for thromboembolism, [Olwin] *1101
GANGLION (tumor)
treatment, hydrocortisone, N.N.R., 51
GANGRENE
gangrenous cholecystitis and peritonitis after unrelated surgery fatal, [Levin] *1010
gas, neuropathology in, Brazil, 1161
in old aged after extremity fractures, [Miller] 598—ab
GARDENING
spring, [Leisure Corner] *1092
GAS
gangrene, neuropathology in, Brazil, 1161
natural, peripheral nerve lesions during coma from, [Olsen] *29
GASTRIC: See Stomach
Ulcer: See Peptic Ulcer
GASTROENTERITIS
toxicosis in infants from, procaine for, [Gluzd] 1000—ab
GASTROENTEROLOGY
British Society of Gastroenterologists, 313
Swiss Society of Gastroenterology, 316
GASTROENTEROSTOMY
megaloblastic anemia after, [Badenoch] 321—ab
GASTROINTESTINAL TRACT
cancer diagnosis in women, yearly physical survey value, [Rutherford & Banks] *1289
disease, chlorpromazine for, [Asher] *1281
disease, epigastric hernia simulating, [Catanzaro] 241—ab
hemorrhage, diagnosis and management, [Berkowitz & others] *1396
hemorrhage in old age, emergency surgery safeguards, [Gilchrist & de Peyster] *1375
hemorrhage with pancreatic tissue in stomach, [Rudnick] 916—ab
poliomyelitis virus (attenuated) given in, for immunization, [Koprowski & others] *954
roentgen study in the newborn, [Carbonell Juan] 682—ab
roentgen study, radiopaque media in, [Davis & others] *373
surgery, noncrushing clamp for, [Rienhoff] *1136
GENERAL PRACTICE: Practitioner: See Medicine, practice; Physicians, practicing
GENETICS: See also Heredity
mutant of muscular dystrophy in mice, 664
mutations causing disease, [Westergaard] 1371—ab
GENITALS
adrenogenital syndrome, Italian congress discusses, 582
cancer, delay in seeking surgical care, [Titchener & others] *1187
cancer diagnosis in women, yearly physical survey value, [Rutherford & Banks] *1289
tuberculosis in women, (antibiotics for) [Halbrecht] 715—ab; (Austria) 1347
GENITOURINARY SYSTEM
surgery, prevent and treat thrombophlebitis and pulmonary embolism in, [Mathe] 917—ab
GEORGES, SAMUEL W., Pope Pius names to Order of St. Gregory the Great, 686
GEORGETOWN UNIVERSITY MEDICAL CENTER
USPHS grant for neurology training, 301
GERIATRICS: See Old Age
GERM WARFARE: See Biologic Warfare
von GIERKE's Disease: See Glycogen storage disease
GLASS
window, sunburn possible through? 1438
GLASSES: See also Lenses
bifocal, in presbyopic ages with myopia, 90
contact, for keratoconus, 249
to protect eyes in welding, 424
GLAUCOMA
Berens-Tolman tonometer evaluated, [Cholst & Horovitz] *661
nitrites for angina contraindicated in? 1004
GLIOMA
cerebral, x-ray for, [Campi] 1368—ab
GLOBULIN
antihemophilic (animal), and surgery in gunshot wounds in a hemophiliac, [Fraenkel] 619—ab
Gamma, Agammaglobulinemia: See Blood, agammaglobulinemia
gamma, effect on poliomyelitis virus excretion after oral immunization, [Koprowski & others] *954
GLOBUS PALLIDUS: See Lenticular Nucleus
GLOSSOPTOSIS: See Tongue
GLUCAGON
production, role of alpha cells [Korp] 813—ab
GLUCOSE
cell respiration inhibited by, Austria, 794
to potentiate sodium salicylate in rheumatism, [Perera] 514—ab
tolerance test, intravenous, [Duncan] 1366—ab
urea in, to reduce cerebrospinal fluid pressure, [David & Settlage] *943
vs. fructose in postinfusion hypoglycemia, *876—E
GLUCURONIDES
excretion in evaluating salicylates for urolithiasis, [Prien & Walker] *255
GLUTAMIC ACID
treatment of liver coma, [McDermott] 593—ab
treatment of phenylpyruvic oligophrenia? 88
GLUTAMIC oxalacetic aminophorase: See Transaminase
GLYCOGEN
storage disease with hepatomata, [Mason] 718—ab
GOATS
hair in coat linings, anthrax from, 52—E
GODFREY, ARTHUR (1903-)
to address Civil Aviation Medical Ass'n., 1244
GOITER
experimental, tribromothyronine in, United Kingdom, 996
from iodide for asthma, [Turner] 903—ab
indications for thyroidectomy in, 920
prevention with iodized salt; deaf-mutism decreasing due to, Switzerland, 995
GOITER, TOXIC
neurothyroid concept of Basedow's disease, [Klotz] 137—ab
treatment, corticosteroids, France, 1252; [Décourt] 1432—ab
treatment, I^{131}, [Cook] 507—ab [Blomfield; Christensen] 515—ab
treatment, Neomercazole, [Kirkeby] 605—ab
treatment, reserpine, [Moncke] 705—ab; [Ottaviani] 804—ab
GOLD
radioactive, aplastic anemia from, [Schoolman & Schwartz] *461
radioactive, for ovary cancer, Austria, 1086
serum colloidal test to diagnose struma lymphomatosa, [Skirpan] 334—ab
GOLF
American Medical Golfing Ass'n. annual tournament, 1526
GONADOTROPINS
chorionic, in geriatrics, [Simeons] 1365—ab
in urine to control testosterone for male infertility, [Charny] *98
treatment of cryptorchism compared to orchiopexy, [Gross & Jewett] *231
GONADS
radiation hazards to nonradiologists, [Ritvo & others] *4
GONORRHEA
treatment, procaine penicillin, Sweden, 896
GOOSE that lays golden eggs, let's save university training hospitals, [Cutler] *282
GORDON, RICHARD
book "Doctor at Large" by, review, England, 314
GOUT
520 cases, [Kuzell] 417—ab
hyperuricemia and, hereditary in, [Hauge] 238—ab
GRADUATES
A.M.A. study on (Bureau article) [Dickinson] *471
Foreign: See Physicians, foreign
survey of trends in specialization, [Weiskotten] *1303
time relation to specialization, [Terris & Monk] *851
GRAND RAPIDS: See Michigan
GRANULOMA
after intratracheal anesthesia, (reply) [Lurie] 90
chemically induced, N. Z., 229
oil, United Kingdom, 701
GRAPEFRUIT
juice, vitamin C standards, (Council report) *1471
GRAVES' Disease: See Goiter, Toxic
GREASE
gun injury, [Noble] 335—ab
GRIEVANCE Committee: See Societies, Medical
GROWTH
chart to record, [Kimball] *1033
effect of illness on, United Kingdom, 584
GUILLEBAUD REPORT of N.H.S. costs, United Kingdom, 996
GUMS
bleeding, significance of 1056—E
gingival sulcus, antibiotics to prevent postextraction bacteremia, [Bender] 806—ab
GYNECOLOGY
surgical, fatal toxic enteritis after antibiotics in, [Baca] 810—ab

H

HACHIYA, MICHIKO, "Hiroshima Diary" by, comments on book review, [Hall] 899—C
HADASSAH Medical School: See Hebrew University
HAHNEMANN MEDICAL COLLEGE
rehabilitation program, 571
HAIR
baldness cures, Dr. Kelvin charged for associating with, United Kingdom, 897
loss from Selsun shampoo, [Grover] *1397
HAND
numb at night, differential diagnosis, (replies) [Ehni; Stephens & Welch] 922
HAND-SCHULLER-CHRISTIAN DISEASE: See Schuller-Christian Syndrome
HANDICAPPED
children, services for, manual, 65
physically, employment; appeal to general practitioners to evaluate, [Maas] 1090—C
President's Committee on Employment of Physically Handicapped Award to Dr. Rowntree, (photo) 677; 782
Puerto Ricans living in U. S., rehabilitation for, 403
HARELIP
cleft palate and, 977—E
HARVEY, WILLIAM (1578-1657)
American Heart Ass'n. presents book on circulation to John Crerar Library, [Katz] *1137
HASHIMOTO'S DISEASE: See Thyroid
HAY FEVER
hyposensitization for, Sweden, 896
HEAD
rolling in man 22, while in bed, 818
HEADACHE
cranial pulse volume in, [Brazil] 1535—ab
from temporomandibular dysfunction, Sweden, 698
histaminic cephalalgia, guest editorial by Dr. Horton, 468—E; (correction) 884
hypothyroidism causes, [Jones] 514—ab
periodic in girl 8 relieved by vomiting, cause; treatment, 1185
treatment, Rauwolfia, [Lewis & others] *622
HEALTH
agencies, cancer program, doctors' opinions on, (Miscellany) *1171
agencies (voluntary) and physicians, [Public Relations] *60
A.M.A. Trustees commend President Eisenhower's program, 678
centers (union) survey, (Council article) *679
education, international conference, Rome, April-May, 1422
education, physicians and health department roles, [Pinckney] *1450
Examination: See Physical Examination
family record, Connecticut physicians distribute [Public Relations] *60
forums, community; Hartford, Conn., 122
hazards of chemicals, A.M.A. symposium, 65
implications of White House conference on education, 120—E
Industrial: See Industrial Health
Insurance: Seen Insurance, sickness
log, guest editorial by Dr. Dragstedt, 1320—E
London's, 1351
Ministry of, England, (bulletin on prescribing) 314; (annual report) 501; (hospital memorandum on newborn infant care) 583; (Mr. R. H. Turton appointed Minister) 585; (diphtheria immunization campaign) 702; (*Brit. M. J.* criticizes poliomyelitis vaccination program) 996
National Health Service (England): See National Health Service
personal, new approaches in preventing chronic illness, [Scheele] *1114; 1145—E
public, emergency handling of frozen foods, [Hozier] 149—ab
public health department and physicians, [Pinckney] *1450
public, national institute reorganized, Peru, 698
public, statistics, Spain, 896
public, WHO in protection from atomic radiation, 1252
services (free) extended, Ireland, 1253
services in India, 696
USPHS, and WHO sponsor symposium on venereal diseases, 129
USPHS, Dr. Davis associate director of National Institute of Allergy and Infectious Diseases, 1423
USPHS, Dr. Murray director of division of biologics standards, 691
USPHS, examinations for medical officers, 888; (need for reserve) 1342

HEALTH—Continued
USPHS grants for Indian health projects, (U. of Arizona for survey) 300; (U. of Pennsylvania to reduce tuberculosis) 376
USPHS hospital and health service grants, 989
USPHS neurology training grant to Georgetown U., 301
USPHS plan for research grants, 1527
USPHS responsibilities in civil defense, [Hozier] *1206; [Christensen] *1209
Week (annual) in Los Angeles County, 61
World Health Organization: See World Health Organization
HEARING: See also Deafness
impaired (otosclerotic), transtympanic stapes mobilization for, [Kos] 1436—ab
loss, perceptive vs. conductive: diagnosis, 728
loss without medical findings, cause? 1438
surgery to preserve, in chronic attic and middle ear disease, [Juers] *451
HEART
Anomalies: See also Ductus Arteriosus; Heart disease (congenital)
anomalies, atrial septal, surgery for, [Farquhar] 595—ab
anomalies, congenital, [Becu] 329—ab
anomalies, ventricular septal, with arteriovenous shunts, [Callahan] 1173—ab
anomalies, ventricular septal, with pulmonary hypertension; pump-oxygenator for surgery, [DuShane & others] *950
arrest, molar sodium lactate in, [Bellet] 237—ab; [Bellet & others] *1293
arrest, operating room deaths, [Briggs & others] *1439
arrhythmia, vagal stimulation and hypoxia effect on, [Jacoby] 516—ab
aspirate air from, after accidental injection into vein, 817
ballistocardiographic cigarette test, [Davis] 1094—ab
block, molar sodium lactate in, [Bellet] 237—ab; [Bellet & others] *1293
catheterization in children, anesthesia for, [Fellman] 516
decompensation, inferior vena cava ligation for, Austria, 1347
disease and rectum cancer: electrolyte imbalance, diarrhea, adrenal insufficiency, and pulmonary edema with, (Diagnostic Problems) [Frazier] *774; (comment) [Bay] *775
disease, Armed Forces course in, 1156
disease, blood aminopherase in, [Merrill & others] *1454
disease (congenital), age effect on hemoglobin level, [Shephard] 1260—ab
disease (congenital) retrograde aortography to diagnose, [Singleton] 328—ab
Disease (Coronary): See Arteries, coronary
disease diagnosis in lung congestion using Valsalva maneuver, [Knowles & others] *14
disease in children, camp for, N. Y., 1336
disease in etiology of cardiac arrest during surgery, [Briggs & others] *1439
disease in old age, nutrition in, [Monat] 708—ab
disease not contraindicate reserpine-Ritalin in old age, [Ferguson & Funderburk] *259
disease relieved more by vodka than by whiskey, why? 610
disease, renal circulation in, France, 1428
disease, reserpine for, [Schumann: Halprin] 705—ab
disease (rheumatic), ACTH and cortisone effects, [Harris] 1095—ab
disease (rheumatic), after mitral commissurotomy and cortisone, [Gil] 240—ab
disease (rheumatic and streptococcic) with systolic murmurs: prognosis, insurance study, [Bolt & Lew] *736
disease (rheumatic), capillary microscopy in, [Davis] 709—ab
disease (rheumatic malignant), France, 1163
disease (thyrogenic) found in diagnosing asthma, [Howes] 1260—ab
electrocardiogram during hypothermia and circulatory occlusion, [Hicks] 1262—ab
electrocardiogram one year after myocardial infarction [Gittler] 1094—ab
electrocardiogram, precordial T waves in diaphragmatic infarction, [Wachtel] 709—ab
electrokymography in normal subjects, Chile, 785
function test, Master 2-step: significance of extra- or extrasupra-ventricular systoles after, 89
hypertrophy (idiopathic), generalized vascular disease in, [DeMuth] 83—ab
hypertrophy in infancy, [Brusca] 243—ab
Infarction: See Myocardium
Inflammation: See also Endocarditis; Myocarditis; Pericarditis
inflammation (rheumatic), course of; hormones for, [Wilson & Lim] *1457
insufficiency (chronic congestive failure), rectal diuretic for, [Makous] 903—ab
insufficiency (congestive failure), hydration and Pitressin or nicotine for, water excretion after, [Hanenson] 1432—ab
insufficiency (congestive failure) with coarctation of aorta in infancy, [Lang] 1176—ab

HEART—Continued
insufficiency, edema with; Dr. Luckey of Cornell U. lectures on, Chile, 786
insufficiency (mild failure), body fluids in, [Walser & others] *858
insufficiency, prednisone for, Switzerland, 994; (correction) 1341
irregularities effect on auricular hemodynamics during thoracotomy, [Wilson] 1263—ab
murmurs (innocent systolic) in childhood, [Stuckey] 716—ab
murmurs (systolic), prognosis; insurance mortality study, [Bolt & Lew] *736
Rate: See Bradycardia; Pulse; Tachycardia
rhythm, molar sodium lactate increases, [Bellet & others] *1293
Surgery: See also Heart, anomalies; Mitral Valve; Pulmonary Valve
surgery at Austrian and Yugoslavian centers, 500
surgery, disposable oxygenator for, [Lillehei] 1095—ab
surgery during pregnancy, Switzerland, 1350
surgery, pump-oxygenator for, [DuShane & others] *950
tamponade after sternal marrow aspiration, [Jenkins] 326—ab
Ventricular Fibrillation: See Ventricular Fibrillation
Ventricular Septal Defect: See Heart Anomalies
HEAT
exchange, humidity effect on, [Burton] 722—ab
therapeutic basis in chills, 608
Therapeutic Use: See also Diathermy
therapeutic use, biophysical basis, [Schwan] *191
therapeutic use in rheumatoid arthritis, [Rae & Bender] *611
therapeutic use in thromboembolism, [Olwin] *1101
HEBREW UNIVERSITY
Hadassah Medical School Institute of Forensic Medicine opened, 582
HEMANGIOMA
capillary (congenital) of parotid gland, [Campbell] 999—ab
of colon, [Bailey & others] *658
of spine, [Ferguson] 330—ab
HEMANGIOMATOSIS
massive osteolysis relation to, [Gorham] 598—ab
HEMATOLOGY: See Blood
HEMATOMA, Subdural: See Meninges
HEMATURIA
in children drinking fluoridated and nonfluoridated water, [Schlesinger & others] *221
HEMIPLEGIA
from amphetamine, United Kingdom, 1430
surgical treatment, hemispherectomy, [Ferey] 1535—ab
HEMISPHERECTOMY: See Brain surgery
HEMOCHROMATOSIS
test for; hemosiderin in epithelial cells of apocrine glands, Switzerland, 995
HEMOGLOBIN
level in congenital heart disease, age effect on, [Shephard] 1260—ab
HEMOLYMPH
from scorpions for scorpion sting, Israel, 581
HEMOLYSIS
during transurethral resection, [Creevy] 916—ab
HEMOLYTIC DISEASE OF FETUS AND NEWBORN
course of, exchange transfusion for, [Betke] 1369—ab
family problem, [Walker] 1435—ab
HEMOPERITONEUM
in granulosa cell cancer, during pregnancy, [Barrett] 1265—ab
HEMOPHILIA
B, Christmas disease, [Golding] 418—ab
gunshot wound in, animal antihemophilic globulin and surgery for, [Fraenkel] 419—ab
transfusion for, basis of, [Brinkhous] 908—ab
HEMOPOIESIS: See Blood formation
HEMORRHAGE
acute condition of abdomen in children, Brazil, 1252
blood volume determinations after, [Meyer] *1312
colitis with, salazopyrin for, Switzerland, 1350
epidemic hemorrhagic fever, Korean type in Europe, [Mayer] 510—ab
exsanguinating, sudden fatal shock in infancy from, 608
postpartum, from fibrinogen depletion, [Klein] 714—ab
shock of, hydrodextran for; blood volume and protein, and excretion studies, [Harrison] 79—ab
subungual, cause of? 921
HEMOSIDERIN
in epithelial cells of apocrine sweat glands, test for hemochromatosis, Switzerland, 995

HEMOSIDEROSIS
pulmonary, in mitral stenosis, [Sacco] 862—ab
HEPARIN
treatment of angina pectoris, [De Matteis] 567—ab
treatment of tinnitus aurium, Austria, 794
HEPATITIS: See Liver inflammation
HEPATITIS, INFECTIOUS (epidemic jaundice)
acute fulminant, ACTH and cortisone for, [Shane] 804—ab
Kentucky and USPHS to study, 783
persistence of abnormal liver tests in carriers, [Norris & others] *1118
serum glutamic oxalacetic aminopherase in, [Wróblewski & LaDue] *1130
treatment, prednisone, Switzerland, 414
HEPATOBLASTOMA (Hepatoma)
glycogen disease with, [Mason] 718—ab
HEPATOLENTICULAR Degeneration: See Lenticular Nucleus
HEPATOMA: See Hepatoblastoma
HEREDITY: See also Families; Genetics; Twins
aspects of choroideremia in woman 26, 727
in aniridia; is it sex-linked? 423
in fibrocystic pancreatic disease, [di Sant' Agnese] *846; (probability after one of 2 children has) 1184
in gout and hyperuricemia, [Hauge] 238—ab
in leptocytosis, United Kingdom, 898
in spherocytosis, [Stenstrom] 803—ab
HERMAPHRODITISM
fetal, hormonal production, [Hoffmann] 1535—ab
HERNIA
epigastric, simulating gastrointestinal disease, [Catanzaro] 241—ab
hiatus (esophageal), pneumoperitoneum to differentiate from angina pectoris, [Maisel & Herger] *808
hiatus (esophageal), regurgitant esophageal ulcer from, [Schmidt] 237—ab
hiatus, in Saint's triad, surgery for, [Palmer] 241—ab
hiatus, of esophagogastric junction, [Texter & others] *830
hiatus, with esophagitis and cardiospasm, [Boyd] 320—ab
Incarcerated: omentum ever become strangulated, infarcted and gangrenous? 1538
inguinal, herniorrhaphy for, United Kingdom, 799
ovarian, in infants, Austria, 1348
spigelian, [Isaacson] 911—ab
umbilical, huge omphalocele ruptured in utero, [Meltzer] *656
HEROIN: See under Morphine
"HIROSHIMA DIARY" by M. Hachiya, comments on book review, [Hall] 899—C
HERPES
in infants from lack of antibodies transmitted from mother, France, 581
Zoster and x-rays, [Seelentag] 918—ab
HESS, ELMER E.
speaks to medical groups, 783; 1243; 1420
trustee-at-large to National Society for Crippled Children and Adults, 1244
HESS, JULIUS HAYS, school named for, Chicago, 982
HEXAMETHONIUM
treatment of hypertension, variables in evaluation, [Shapiro] *30
treatment plus reserpine in hypertension, [Crawley] 705—ab
HEXOBARBITAL
anesthesia fatal, United Kingdom, 1532
HEXYLCAINE HYDROCHLORIDE
topical, for endoscopy, [Orkin & Rovenstine] *1465
HIBERNATION, ARTIFICIAL
adrenal function in, [Egdahl] 722—ab
effect on inflammation, [Furpura] 138—ab
effect on occlusion of afferent brain circulation, [McMurrey] 1097—ab
electrocardiogram in, [Hicks] 1262—ab
for cardiovascular surgery in sheep, N. Z. 229
for toxic infection of infants, [Crisalli] 1177—ab
for toxic porphyria, [Muller] 1365—ab
to interrupt aortic circulation, [Parola] 910—ab
using ice only, France, 133
vital organs in, [Knocker] 80—ab; [Brancadoro] 334—ab
HILL-Burton Act: See Hospitals
HIP
arthrosis, hydrocortisone for, Denmark, 499; [Andersen] 712—ab; (X-ray compared) [Rasmussen] 712—ab
Fracture: See Femur fractures
skin cap arthroplasty, Finland, 580
HIRSCHSPRUNG'S Disease: See Colon, megacolon
HISTAMINE
cephalalgia, guest editorial by Dr. Horton, 468—E; (correction) 884
in Blood: See Blood
liberation at site of allergic manifestation, India, 993
to combat stress in rheumatism, [Perlstein] 708—ab

HISTOPLASMOSIS
recent studies, [Egbert] 592—ab
HOBBIES: See also Physicians, avocations
Hobby Show for Older Persons, N. Y., 1337
HODGKIN'S DISEASE
alcohol sensitivity as symptom, [Godden & others] *1274
atypical cases, Brazil, 795
mortality in U. S., 1921–1951; leukemia compared, [Shimkin] 721—ab
treatment, acetazolamide, renal lesions after, [Glushien & Fisher] *2064
treatment, actinomycin C, England, [Trounce] 507—ab; 581
treatment, p-(di-2-chloroethyl-amino)-phenylbutyric acid, England, 132; [Galton] 331—ab
treatment, Novembichin or Dopan, United Kingdom, 1429
treatment, sodium radiophosphate, Austria, 1846
HOGS
caliber of pericardial lymphatic capillaries in Yorkshire piglets, 570
whole body x-irradiation, STH effect on, [Baxter] 515—ab
HOHL, ELIZABETH MASON, Medical Woman of the Year, 61
HOME
care program at California hospital, 982
consultation fees by specialists in N. H. S. England, 227
prothrombin determination at home, (replies) [Manchester; Bruce] 342
treatment program for rheumatoid arthritis, [Rae & Bender] *611
HOMICIDE: See Murder
HOMOSEXUALITY
R. M. A. to study law and practice of, United Kingdom, 699
legalized, advocated in England, 74
HORDER, THOMAS JEEVES, 1st baron (1871–1955)
memorial proposed for traveling professorship, United Kingdom, 1089
HORMONES
cause of fetal hermaphrodism, [Hoffmann] 1535—ab
cause of varicose veins in pregnancy, [Fried] 1535—ab
given to capons harmful? 1004
Laurentian Hormone Conference, 1420
treatment of metastatic breast cancer, [Pearson] 324—ab; (vs. x-ray) [Garland] 580-C
treatment status in leukemia, (Council report) *1228
HORTON, BAYARD T., guest editorial: hisjamimic cephalalgia, 468—E; (correction) 884
HOSPITALS: See also Medicolegal Abstracts
at end of letter M
Accreditation: See Joint Committee on Accreditation of Hospitals
administration course at Cornell U., 881
agrees with press on releasing patient information, England, 72
American Hospital Ass'n. room rule survey, 573
Army (European), Dr. Vail tours, 691
Atlantic City, visiting chiefs pro tem, 784; 1140
bed shortage vs. other facilities, United Kingdom, 584
beds, emergency service, United Kingdom, 1167
beds (private), shortage, United Kingdom, 502
Bronx, new cardiac clinic, 63
cesarean section, acceptable rate, 926; 921
children's daily visiting by parents encouraged, United Kingdom, 502
Children's Orthopedic, cardiology fellowship, Wash., 404
civil defense, guide in organizing, N. Y., 685
civil defense, mobile unit for, [Olson & others] *1202; [Howard & others] *1211
civil defense planning and requirements, [Whitney] *1195
clinical record removed from by patient, United Kingdom, 898
conductive floor problems, 1099
cook shortage, United Kingdom, 702
cost in N. H. S., Guillebaud report on, United Kingdom, 996
cost inquiry by British Parliament, 798
Evanston, gifts by medical staff, Ill., 62
extravagant use of blood in, United Kingdom, 504
general, transfer tuberculosis patient to, for surgery? 423
genitourinary, metabolic unit, United Kingdom, 1256
Hartford, unit for minor surgery and treatment, 61
heroin ban, supply and substitute problems, England, 314; (ban lifted) 502
Hospital for Special Surgery to build Caspary Research Building, N. Y., 303
in Iowa, practice of pathology and radiology by, held illegal, 53—E; [Medicine and the Law] 58
in Korea, request surplus drugs for, especially for tuberculosis, [Codington] 232—C
HOSPITALS: Continued
in Northern Ireland, general practitioners appointments in, 412
in Ontario, morbidity in, Canada, 1088
in Scotland, new, 702
infection control, England, 225
infections occurring in, 290—E
insurance plans, Canada, 1087
International Hospital Federation study tour in Ireland, 406
Interns: Internships: See Interns and Internships
Jewish Hospital of St. Louis receives funds for psychiatric and hydrotherapy units, 123
mental, admissions, Canada, 1088
mental, in Alaska, Dr. Lull writes to U. S. Senate on proposed legislation, 1235
mental, in Connecticut, the aged in, [Shindell & Cornfield] *1121
mental, in Scotland, new class of patients proposed, 701
mental, United Kingdom, (changing population in) 585; (crisis in) 1352; (workshop in) 1450
mental, V. A. program for long-term patients, 589
Metropolitan, on Welfare Island completed, 123
Mt. Sinai in Miami, cardiovascular pathology fellowships, 1201
Mount Zion home care program for chronic diseases, Calif., 982
National Hospital Week, emphasizes disaster planning, 526—E
National Jewish, building fund, Colo., 300
New England, plan for alien women physicians, guest editorial by Dr. Bearse, 562—E
nursery, Ministry of Health memorandum on care in, United Kingdom, 583
nursery, preventing epidemic diarrhea in, [Janssen] 718—ab
Operating Room: See Surgery
patients, admission for alcoholics, Ill., 402
patients, wandering Leo Lamphere at Camarillo State Hospital, [Chapman] 415—C
physician relationships, A.M.A.–A.H.A. Liaison Committee to be continued, 1322
Pinal General, Hill-Burton funds for nursing home addition, Ariz., 61
Residents: Residencies: See Residents and Residencies
Rhode Island, addition dedicated, (photo) 124
Riksh ospitalet in Oslo, memorial fresco showing Hippocrates and Leonardo da Vinci, 583
St. Michael's, Newark, cardiology fellowships, 217
staphylococcus in, nasal and faecal carriers, [Brodie] 904—ab
statistics, United Kingdom, 701
tissue committee in accreditation [Medicine and the Law] *1230
USPHS grants for research, 989
University, for training medical students, economic problems, [Cutler] *2282
VA, completed at Sepulveda, Calif., 888
VA plan for patient discharge, 691
HOUSSAY, BERNARDO A. (1887–)
reinstated in U. of Buenos Aires, 687
HOXSEY CANCER TREATMENT
FDA warns against, 1423
HUMERUS
fractures of external condyle, [Milch] *641
HUMIDITY
effects on heat exchange, [Burton] 722—ab
HUNTERIA
chutnen pichon for hypertension, France, 133
HUNTERIAN SOCIETY
debate necessity of capital punishment, England, 413
HUXLEY POSITIVE-PRESSURE VALVE for respiration by uncuffed tracheostomy tube, [Morch & others] *864
HYALINE MEMBRANE
in asphyxia of newborn, [Gitlin] 1177—ab
in fetal aspiration syndromes, x-ray patterns, [Petterson] 148—ab
in premature infants [Rogers] 716—ab
HYALURONIDASE: See also Antihyaluronidase
to prevent renal calculi in poliomyelitis, [Taylor] 330—ab
treatment by iontophoresis for lymphedema after mastectomy, (reply) [Funk] 90
treatment of venous congestion of legs, [Gibson] 712—ab
HYAZINE: See Hyaluronidase
HYDANTOIN
Methylphenyl: See Methylphenyl Hydantoin
HYDRALAZINE HYDROCHLORIDE
toxicity, L.E. cell as sign, [Comens & Schroeder] *1134
treatment of eclampsia [Cossutta] *2—ab
treatment of hypertension, [Coan] 593—ab
treatment of hypertension, variables in evaluation, [Shapiro] *30
HYDRATION
Pitressin or nicotine with, for congestive heart failure, water excretion after, [Hanson] 1432—ab
1-HYDRAZINOPHTHALAZINE: See Hydralazine
HYDROCHLORIC ACID
remove poisonous insecticides from fruits and vegetables? 699
HYDROCORTISONE
cyclopentylpropionate, N.N.R., 289
intramuscular use, N.N.R., 777
ointment evaluated, [Mullins] 244—ab
ointment, India, 797
sodium succinate, N.N.R., 389
treatment (intravenous) of adrenal insufficiency during surgery, [Howland & others] *1271
treatment of arthritis compared to prednisone and prednisolone, [Boland] *613; (reply) [Brick] 1168—C
treatment of arthroses, Denmark, 499; [Andersen] 712—ab
treatment of Dupuytren's contraction and allied conditions, [Zacharias] 421—ab
treatment of ganglion, N.N.R., 51
treatment of keloids, [Achoc-Hansen] 603—ab
treatment of otitis deformans? 250
treatment of rheumatic carditis, [Wilson & Lim] *1457
treatment of Tietze's syndrome, [Celio] 244—ab
treatment plus streptomycin–isoniazid in early tuberculous meningitis, [Cocchi] 1009—ab
HYDROCORTISTAT
treatment of arthrosis compared to x-rays, [Rasmussen] 712—ab
HYDROCORTONE: See Hydrocortisone
HYDRODEXTRAN
treatment of hemorrhagic shock, [Harrison] 79—ab
HYDROHYDRATION
to determine tube patency with saline, [Yagi] 328—ab
o-HYDROXYBENZAMIDE: See Salicylamide
17-HYDROXYCORTICOSTERONE: See Hydrocortisone
21-HYDROXYPREGNANEDIONE SODIUM SUCCINATE
anesthesia, [Gordan] 1002—ab; [Murphy] 1002—ab
5-HYDROXYTRYPTAMINE
excretion after lysergic acid diethylamide for mental patients, United Kingdom, 1353
test for carcinoid, United Kingdom, 898
HYGIENE
Industrial: See Industrial Hygiene
new food laws, United Kingdom, 700
HYPAQUE: See Diatrizoate Sodium
HYPEREMESIS GRAVIDARUM: See Pregnancy, vomiting in
HYPERFOLLICULINISM: See Estrogens
HYPERSENSITIVITY: See Allergy
HYPERTENSION: See Blood Pressure, High
HYPERTHYROIDISM
in childhood, thiouracil for, [Van Wyk] 1536—ab
treatment, I^{131}, leukemia after, [Pochin] 1180—ab
HYPERURICEMIA: See Uric Acid
HYPNOSIS
in pregnancy and labor, Christian Science vs., (reply) [Davis] 76—C
HYPNOTICS
use and abuse, [Wolff] 1176—ab
HYPOCHONDRIASIS
increasing, England, 74
Munchausen syndrome, England, 226
HYPOTENSION: See Blood Pressure, low
HYPOTHERMIA, ARTIFICIAL: See Hibernation, Artificial
HYPOTHYROIDISM
as a cause of headache, [Jones] 514—ab
HYPOXIA: See Oxygen deficiency
HYSTERECTOMY: See Uterus
HYSTERIA
after railway accident, patient awarded damages, United Kingdom, 502
HYSTEROSCOPE: See Uterus

I

INCAP: See Institute of Nutrition of Central America and Panama
IDENTIFICATION
tags for civilians, Sweden, 698
wanted by F.B.I. of man treated for x-shaped wound on face, 215
ILEOCECAL VALVE
lesions, differential diagnosis, [Sauer] 596—ab
ILEUM
closed-loop obstruction from appendical knot, [Mikal & Byers] *19
ILEUS: See Intestines obstruction
ILLINOIS Department of Welfare grant to Northwestern for narcotic addiction research, 683
ILOTYCIN: See Erythromycin
IMMIGRANTS
Physicians: See Physicians, foreign
Yemenite, morbidity among, Israel, 581
IMMUNITY
vaccine dosages for children for Asiatic travel, safe combinations for adults, 817
vascular purpura an immunologic disease? [Kreidberg] 602—ab
IMPOSTORS
Frederick (George W.) using Dr. C. A. White's name to obtain drugs, 687
Lamphere (Leo), wandering patient now at Camarillo State Hospital, [Chapman] 415—C

IMPOSTORS—Continued
Munchausen syndrome, England, 226
warning, especially in rural communities having no physician, 216
INCOME Tax: See Tax, income
INDEMNITY Insurance: See Medicolegal Abstracts at end of letter M
INDEX-CATALOGUE of Surgeon General closed, changes in Library publications, [Rogers] 801—C
INDIA
epidemiological approach to larynx cancer etiology in, [Wynder & others] *1384
Indian Council on Medical Research Convention, 796
INDIANA UNIVERSITY
School of Medicine, visiting professors, 1418
INDIANS, AMERICAN
Navajos, request drug samples especially vitamins for [Cullen] 415—C
USPHS grants for health projects, (to U. of Arizona for survey) 300; (to U. of Pennsylvania to help reduce tuberculosis) 576
INDIGENT: See Medically Indigent
INDIGESTION
"home dyspepsia" in infants, oxytetracycline for, [Schaper] 329—ab
treatment, chlorpromazine, [Asher] *1281
INDUSTRIAL ABSENTEEISM: See Industrial Health workers
INDUSTRIAL ACCIDENTS
A.M.A. reprint on vision loss, 295
fatigue ulnar fractures, [Evans] 913—ab
grease gun injury, [Noble] 335—ab
wrong finger amputated after, patient awarded damages, United Kingdom, 701
INDUSTRIAL DERMATOSES
aspects of, [Klauder] *442
chlorpromazine, in nurses and pharmacists, England, 74
from fabrics, [Braitman] 421—ab
medical director's standpoint, [Lauer] 1096—ab
INDUSTRIAL DISEASES
bronchogenic neoplasms, [Breslow] 1096—ab
cadmium poisoning and byssinosis, United Kingdom, 1167
chronic cough and bronchospasm from trichloroethylene? 248
emphysema (pulmonary) relation to dust exposure, (reply to Dr. Sander) [Mayer & others] 230—C
"espresso" wrist from operating coffee dispenser, United Kingdom, 1532
lead poisoning in relation to climate, [Shiels] 335—ab
leukemia hazard in atomic energy plants? 151
liver disease from poisoning, [Thompson] 86—ab
methyl bromide poisoning, France, 1163
radiation hazards to nonradiologists, [Ritvo & others] *4
radioactivity damage in luminous dial workers, [Looney & Colodzin] *1
Silicosis; Pneumonoconiosis: See Pneumonoconiosis
tuberculosis among nurses, [Myers] 908—ab; (preventing in students) 1183
INDUSTRIAL HEALTH
A.M.A. Annual Congress, 53—E; (program) 56; (report) 676
effects of low-level radioactivity in Columbia River, [Henderson] 1180—ab
employing physically handicapped, appeal to general practitioners to evaluate, [Maas] 1090—C
employment conditions for epileptic schoolteachers, England, 74
medicine, nurse and medical department in, 677
national congress on, Italy, 1164
physicians needed, 1411—E
preemployment examinations of low back, [Diveley & Oglevie] *856
principles and procedures for nurses, A.M.A. publication on, 781
rehabilitation of veterans with circulatory ailments, 309
skin testing of industrial compounds, polyvalent sensitivity develops [von Haam] 603—ab
syphilis in cook with positive serotests but no disease, danger of transmission? 1100
workers, absenteeism, (A.M.A. to gather statistics) 676; (A.M.A. publications on) 781
workers, the elderly, United Kingdom, 1256
INDUSTRIAL HYGIENE
bulletins on occupational health hazards, 65
edathamil calcium-disodium for lead exposure, [Manville] 86—ab
protecting eyes of welder and employees nearby, 424
INDUSTRIAL TRADE UNIONS
health centers, survey of, (Council article) *679
INFANTS
antipyretic-analgesic for, N-acetyl-p-aminophenol, [Cornely & Ritter] *1219
diphtheria and tetanus toxoids, potency and dosage control, [Greenberg & Benoit] *108

INFANTS—Continued
feeding (breast) and infection, United Kingdom, 898
feeding, give lactose in milk-free diet to infant with galactosemia? 341
feeding in preventing iron deficiency anemia, guest editorial by Dr. Jackson, 976—E
feeding, mothers wear masks? 1438
"home dyspepsia," oxytetracycline for, [Schaper] 329—ab
ovarian hernia in, Austria, 1348
premature, elimination of retrolental fibroplasia in, [Guy] 1536—ab
premature, lung hyaline membranes in, [Rogers] 716—ab
prematurity and walking, United Kingdom, 1256
prematurity risk after 4 or more cesarean sections, [McNally & Fitzpatrick] *1005
procaine for toxicosis from gastroenteritis in, [Giusti] 1000—ab
protection against tuberculosis, [Gaisford] 84—ab
surgery (early) for prognathism, Italy, 133
tuberculosis in, is Vollmer test indicative of? 726
what mothers prescribe, England, 73
INFANTS, NEWBORN
asphyxia of, hyaline membrane in, [Gitlin] 1177—ab
bronchopneumonia in, Austria, 1426
capillary hemangiomas of parotid gland in, [Campbell] 999—ab
diagnosis and therapy of stenosis of aortic isthmus, [Gruner] 243—ab
E. coli infection in, Brazil, 313
edema (sclerema) in, ACTH for, [Nuñez] 1177—ab
endemic micrococcic puerperal mastitis effect on, [Ferrario] 1369—ab
epidemic diarrhea of, preventing, [Janssen] 718—ab
heart anomalies in, [Becu] 329—ab
hepatitis fatal in siblings, giant multinucleated liver cells in, [Krainin & Lapan] *937
hermaphrodism in, hormonal production, [Hoffmann] 1535—ab
herpes in, from lack of antibodies transmitted from mother, France, 581
liver rupture with recovery, [Greaves] 716—ab
metabolism and kidney function, Austria, 1161
Ministry of Health memorandum for improving hospital care, United Kingdom, 583
myocarditis from Coxsackie B virus in, [Javett] 810—ab
Nursery for: See Hospitals, nursery
omphalocele (huge) ruptured in utero, intestinal resection for, [Meltzer] *656
palpable contractile pyloric tumors in, [Craig] 916—ab
pertussis vaccination in, England, 413
poliomyelitis (subclinical) in, from intrauterine infection, [Shelokov & Habel] *465
poliomyelitis immunity conferred to, 152
Premature: See Infants, premature
Rauwolfia for maternal toxemia and hypertension effect on nose congestion in, [Finnerty] 997—C; [Rogers] 1090—C
Robin's syndrome in, [Jaso] 811—ab
sudden shock from exsanguinating hemorrhage: incidence of liver damage during labor in? 608
x-ray patterns of hyaline membrane and fetal aspiration syndromes, [Petterson] 148—ab
x-ray study of gastrointestinal tract, [Carbonell Juanico] 602—ab
INFECTION
absent in recurrent renal calculi, [Baker & Connelly] *1106
agents in sewage after disposal plant treatment, 877—E
benign conditions simulating bone tumors, [Collins & Collins] *425
breast feeding and, United Kingdom, 898
chronic, fatal after abdominal surgery in old age, [Gilchrist & de Peyster] *1375
chronic, iron metabolism in anemia of, [Bush] 904—ab
from Mima organisms, 1183
in hospitals, 290—E
in hospitals, control, England, 225
mixed, in fistulating bone tuberculosis, [Behrendt] 79—ab
surgical, tetracycline for, [Pulaski] 1097—ab
toxic, of nurslings, artificial hibernation in, [Crisalli] 1177—ab
treatment, penicillin V, [Martin & others] *928
INFECTIOUS DISEASES
national advisory council announced by surgeon general, 989
National Institute of Allergy and Infectious Diseases established, 576; 1423
neurovegetative syndrome with visceral vasodilation, Switzerland, 1253
INFERTILITY: See Sterility
INFLAMMATION
abdominal (acute), in children, Brazil, 1252
artificial hibernation and, [Purpura] 138—ab
benign conditions simulating bone tumors, [Collins & Collins] *431
C-reactive protein test for, 674—E

INFLUENZA
clarification of flu and intestinal flu, 608
incidence, United Kingdom, 799
vaccine trial, diagnostic methods, [McDonald] 320—ab
vaccine trial, M.R.C. report on oil and saline adjuvants, England, 132; [Stuart-Harris] 321—ab
viruses, age factor in antibody response post-epidemically, [Hennessy] 320—ab
INJECTION
antihistamines to prevent and treat transfusion reactions, N.N.R., 777
by nun, paralysis after; surgeon's responsibility, France 1163
intramuscular, avoid in poliomyelitis epidemic? 921
intramuscular chloramphenicol, N.N.R., 671
intramuscular hydrocortisone, N.N.R., 777
paravertebral cortisone in spine osteoarthritis, (replies) [Pruce] 899—C; [Cohen] 1355—C
parenteral, new injector minimizes pain, [Figge & Gelhaus] *1308
parenteral, of drugs, 1233—E
INJURIES: See Accidents; Trauma
Industrial: See Industrial Accidents
INK
potassium hydroxide and, myocological stain, [Robinson & others] *537
INSANITY: See Mental Disorders
Manic Depressive: See Psychosis
INSECTICIDES
"moth-ball" potatoes from, England, 74
poisonous, will HCl remove? 609
INSTITUTE: See also Societies and Other Organizations at end of letter S
of Forensic Medicine of Hadassah Medical School opened, 582
of Nutrition of Central America and Panama, program, (Council statement) *561
of Physical Medicine and Rehabilitation at Bellevue, aphasia retraining words from, 816
INSTRUMENTS
A.M.A. pamphlet on quackery, 1333
injector minimizes pain of parenteral therapy, [Figge & Gelhaus] *1308
noncrushing clamp for gastroenterological operations, [Rienhoff] *1136
rotatable anoscope, [Abramson] *874
INSULIN
clinical aspects of hyperinsulinism, [Breidahl & others] *198
deficiency same as diabetes? [Gerritzen] 1173—ab
islet-cell tumor with hyperinsulinism; surgery and alloxan fail, [Fisher] 334—ab
non-specific effects, [Marley] 809—ab
shock treatment in schizophrenic diabetics, Austria, 499
INSULOMA (insulinoma)
symptomatology, [Pedrazzini] 908—ab
INSURANCE
Accident: See Medicolegal Abstracts at end of letter M
Indemnity: See Medicolegal Abstracts at end of letter M
life, prognostic value in mortality investigations, [Bolt & Lew] *736
malpractice, A.M.A. Law Department study, 393—E; [Medicine and the Law] *395
sickness, Canada, 1087
sickness, German physicians' stand on Adenauer reform, 228
Sickness, National Health Service: See National Health Service
sickness, Social Welfare vs. Peruvian Medical Ass'n, 1164
sickness (voluntary), A.M.A. survey of physicians' attitudes, 469—E
INTELLIGENCE
child neglect and, United Kingdom, 1352
in cerebral palsy, [Ahnsjö] 808—ab
tests and myopathies, Italy, 1164
INTERNATIONAL: See also list of Societies at end of letter S
College of Surgeons, regional branch at Poços de Caldas, Brazil, 1427
Congress of Medical Ethics, first, discussed drug clinical testing, France, 695
medical organizations, [Visscher] 135—C
Symposium on Radioactive Isotopes in Medicine, Austria, 1086
INTERNS AND INTERNSHIP
number, 159:251, Sept. 24, 1955; (supplementary list and corrections) 160:212, Jan. 21, 1956
INTESTINES
Amebic Infection: See Amebiasis; Colitis, amebic
biopsy, United Kingdom, 1353
coli bacteria recolonization after sterilization, [Zettler] 242—ab
diverticulitis, antibiotics for, 921
diverticulosis, France, 1162
ileocecal junction defects, diagnosis, [Sauer] 596—ab
infection and leukoderma, India, 797
infection (viral) recurrent in, treatment, 1438
inflammation, enteritis fatal after antibiotic therapy, [Baçaj] 810—ab
inflammation, enteritis (regional), x-ray findings, [Marshak] 606—ab

INTESTINES—Continued
inflammation, enterocolitis from antibiotics fatal, [Cuningham] 1175—ab
inflammation, enterocolitis postoperatively, [Schotz] 1174—ab
Intussusception: See Intussusception
lipodystrophy, extraintestinal x-ray signs, [Kyler & Doub] *534
metaplasia in gastric mucosa, cancer arising in, [Morson] 514—ab
obstruction in granulosa cell cancer during pregnancy, [Barrett] 1285—ab
obstruction (meconium ileus) with fibrocystic pancreas, [di Sant'Agnese] *846
obstruction (postoperative), (long tubes for) [Smith] *266; (paralytic, pantothenic acid to prevent) [Orecchia] 1367—ab
parasites: Strongyloides stercoralis, specific treatment? 151
polyps and pigment in Peutz-Jeghers syndrome, [Freeman] 327—ab
roentgen abnormalities after prolonged cathartic ingestion, [Heilbrun] 246—ab
surgery, resection for omphalocele ruptured in utero, [Meltzer] *656
surgery, resection in old age, [Gilchrist & de Peyster] *1375
INTUSSUSCEPTION
intestinal, diagnosis and treatment in childhood, [Reifferscheid] 1433—ab
INVESTMENTS
doctor and municipal bonds, (Business Practice) [Burgert] *136; (reply) [Walker & Robinson] 800—C
of association funds, [Norby] *1331
what happens while you are in Europe? (Business Practice) [Mitchell] *78
IODIDES
tridihexethyl: See Tridihexethyl Iodide
IODINE
Radioactive: See also Radio-Iodinated Serum Albumin
radioactive, for hyperthyroidism; leukemia after, [Pochin] 1189—ab
radioactive, for thyroid cancer with lung metastases, [Catz & Starr] *1046
radioactive, for thyrotoxicosis, [Blomfield: Christensen] 515—ab
radioactive, for toxic adenomatous goiter, [Cook] 507—ab
radioactive, to determine tissue preservation in thyroidectomy [Szilagyi] 139—ab
toxicity: goiter, [Turner] 903—ab
IODIPAMIDE METHYLGLUCAMINE
N.N.R., 1405
IODIPAMIDE, SODIUM
for cholangiography, Austria, 1161
for intravenous cholangiography, [Wise & O'Brien] *819
to detect patency of bile ducts, [Walters] *425
IODIZED OIL
dangers in pulmonary tuberculosis, [Perry] 246—ab
injection into trachea for bronchography safe? 88
IODIZED SALT: See Salt
IODOQUINOLINES
treatment status in amebiasis, (Council report) *1210
ION TRANSFER
hyaluronidase by iontophoresis for lymphedema after mastectomy, (reply) [Funk] 90
IONTOPHORESIS: See Ion Transfer
IOWA
hospitals practice of pathology and radiology held illegal, 53—E; [Medicine and the Law] 58
IRON
colloidal saccharates for iron deficiency anemia, Austria, 1086
deficiency anemia in infants, guest editorial by Dr. Jackson, 976—E
metabolism in anemia from chronic infection, [Bush] 904—ab
ISLANDS of Langerhans: See Pancreas
ISONIAZID
effect on pregnancy, [Aboulker] 1535—ab
in plasma and cerebrospinal fluid after oral administration, [Malosetti] 238—ab
to prevent experimental tuberculosis, [Ferebee] 906—ab
treatment, intracavitary, in pulmonary tuberculosis, [Racine] 137—ab
treatment, lung eosinophilia during, [Perreau] 147—ab
treatment of bone and joint tuberculosis, [Canno] 596—ab; [Smith] 597—ab
treatment of breast tuberculosis, Austria, 795
treatment of mental disorder, [Hewat] 143—ab
treatment of primary tuberculosis in children, [Raynaud] 1433—ab
treatment of pulmonary tuberculosis, bacilli resistance after, [Best] 417—ab
treatment of renal tuberculosis, [Lattimer & others] *544
treatment plus nicotinaldehyde thiosemicarbazone in tuberculosis, Ireland, 1253
treatment plus streptomycin and PAS in pelvic tuberculosis, 152
ISONIAZID—Continued
treatment plus streptomycin and PAS in pulmonary tuberculosis, [Tucker] 323—ab
treatment plus streptomycin-hydrocortisone in tuberculous meningitis, [Cocchi] 1060—ab
treatment plus streptomycin in pulmonary tuberculosis, United Kingdom, 1166
treatment plus streptomycin in tuberculous meningitis, United Kingdom, 1254
treatment plus streptomycin or PAS in tuberculosis, [Hoyle] 707—ab
treatment plus streptomycin, PAS and early surgery in tuberculosis, [Allen] 508—ab
ISONICOTINIC ACID HYDRAZIDES: See Isoniazid
ISOPROPYLARTERENOL: See Isoproterenol
ISOPROPYLTHIADIAZOL
treatment (oral) of diabetes, Austria, 499
ISOPROTERENOL (Isopropylarterenol)
treatment (adjunct) of chronic pulmonary emphysema, (N.N.R.) 50; [Leslie & others] *1125
ISUPREL: See Isoproterenol

J

J.A.M.A.: See American Medical Association Journal
JACKSON, ROBERT L., guest editorial: iron deficiency anemia in infants, 976—E
JAUNDICE
blood aminophenase in, [Wróblewski & LaDue] *1130; [Merrill & others] *1454
Epidemic: See Hepatitis, Infectious
etiology: chlorpromazine, [Isaacs] 146—ab; [White] 720—ab; [Lindsay] 813—ab; [Menguy] 1178—ab
JAWS
Costen's syndrome, headache from temporomandibular dysfunction, Sweden, 698
JEJUNUM
diverticula cause flatulence, abdominal cramps, and irritability? 520
JENKINS-KEFAUVER BILL
explanation by Congressman Keogh, 1234
JEWS
morbidity among Yemenite immigrants, Israel, 581
JOHN CREAR LIBRARY
American Heart Ass'n. presents Harvey's book on circulation to, [Katz] *1137
JOINTS
Blood Council, President Eisenhower encourages; new plans, 981
Commission on Accreditation of Hospitals, (standards for medical records) 294; (A.M.A. requests physicians' comments on function of) 879; (tissue committee in accreditation) [Medicine and the Law] *1238
Commission on Mental Illness and Health, guest editorial by Drs. Bartemeier and Appel, 392—E; (Dr. Plunkett, associate director) 879
Committee on Health Problems in Education, annual session; preparing book, 1323
JOINTS
degenerative joint disease, concomitant pain in back and abdomen, [Lewin] 1257—C
degenerative joint disease, paravertebral cortisone for, (replies) [Fruce] 899—C; [Cohen] 1355—C
degenerative joint disease, succinate-salicylate for, [Gilpin] 1261—ab
pain in splenectomized patient with purpura, treatment, 1438
popping, cause, 424
Surgery: See Arthroplasty
temporomandibular dysfunction, headache from, Sweden, 698
Tuberculosis: See also Arthritis, tuberculous
tuberculosis, treatment, [Campos] 596—ab; [Smith] 597—ab
JOURNALS
British Journal of Tuberculosis and Diseases of the Chest, January golden jubilee number, 985
British Medical Journal criticizes N.H.S. on poliomyelitis vaccination program, 996
bulletin of Joint Commission on Accreditation of Hospitals, reprint on Medical Records, 294
Chronic Illness News Letter, A.M.A. to publish, 292—E
Journal of the A.M.A.: See American Medical Association
new: Journal of Forensic Sciences, 404
new: Nuclear Science and Engineering, 305
new: Revue française d'études cliniques et biologiques, 1235
new: Scottish Medical Journal incorporates Edinburgh and Glasgow Medical Journals, 898
new: Survey of Ophthalmology, 64
reprint requests, enclose return envelope, (Sterling) 801—C; (reply) [Davidsohn] 1533—C
Revista do Instituto Adolfo Lutz dedicated to Dr. Lutz' centennial, Brazil, 1161
Tidsskrift for den norske laegeforening, 75-year jubilee, 500
Yale Journal of Biology and Medicine, issue dedicated to Dr. Fulton, 568

K

KELOIDS
after thyroidectomy in younger people, prevent or treat? 248
blastomycosis with, Brazil, 580
treatment, hydrocortisone, [Asboe-Hansen] 603—ab
KELVIN, JOHN, unethical charge against for associating with baldness cures, United Kingdom, 897
KERATOCONJUNCTIVITIS
epidemic, relation to APC virus syndrome, [Ormsby] 331—ab
KERATOCONUS
cyclodialysis not recommended, contact glasses or keratoplasty for, 249
KEROSENE
poisoning, especially in children, 1110—E
KIDNEYS
artificial, France, 1530
artificial, Lt. Commander Doolan commended for work on, 888
biopsy (needle) in lower nephron nephrosis, [Casey] 330—ab
biopsy (needle), 100 successful cases, [Parrish] 331—ab
calculi and hyaluronidase in poliomyelitis, [Taylor] 330—ab
calculi (bilateral recurrent), collagen abnormality in, salicylates for, [Baker & Connelly] *1106
calculi or colic, prognosis; insurance mortality study, [Holt & Lew] *736
circulation in heart disease, France, 1428
complications in diabetes, low protein diet for, [Allen] 135—C
congenital unilateral multicystic, [Spence] 917—ab
disease in cardiovascular disease, prognosis; insurance mortality study, [Holt & Lew] *736
disease in hypertensive cardiovascular disease, [Smithwick & others] *1023; (lung consolidation in signs) [Howes] 1280—ab
disease, lower nephron nephrosis from toxic solvents, [Casey] 330—ab
disease, nephrosis, ACTH for, [Frederikse] 329—ab
disease, nephrosis, acetazolamide for, Austria, 794
disease, nephrosis from edathamil calcium-disodium, [Foreman & others] *1042
disease, nephrotic syndrome; etiology, prognosis, 727
disease, nephrotic syndrome in children; treatment, [Rance] 716—ab
disease, nephrotic syndrome; malaria therapy in, [Gilbertsen & Basbour] *25; [Gairdner] 329—ab
excretion of Per-Abrodil, Austria, 1087
function after surgery for aneurysm of aorta involving renal artery, [Ellis] 595—ab
function and neonatal metabolism, Austria, 1161
function in children drinking fluoridated and nonfluoridated water, [Schlesinger & others] *21
homotransplantation successful between identical twins, [Merrill & others] *277
Inflammation: See Nephritis
lesions after acetazolamide (Diamox), [Glushien & Fisher] *204
pathology in severe infantile hypercalcemia, [Schlesinger] 1434—ab
polycystic, prognosis, Belgium, 1349
surgery, nephrectomy: inferior vena cava ligation after, [Bolman] 1368—ab
tuberculosis, [Wu] 812—ab
tuberculosis, isoniazid effect on pregnancy, [Aboulker] 1535—ab
tuberculosis; streptomycin, isoniazid and PAS for, [Lattimer & others] *544
tubular necrosis after abortion, [Bull] 1434—ab
tubular pathology after neomycin, [Powell & Hooker] *557
tumors, fibroma, India, 75
tumors, hemangioma, [Ferguson] 330—ab
tumors, nephroblastoma in children, United Kingdom, 1430
unilateral hypertension, nephrectomy cures, [Kobayashi] *810—ab
KINADEN: See Hyaluronidase
KNEE
arthrosis, hydrocortisone for, Denmark, 499; [Andersen] 712—ab; (X-ray compared) [Rasmussen] 712—ab
traumatic calcification of medial collateral ligament, 727
KNIFE
cold, conization procedure in cervical biopsy, [Scott & Reagan] *343
KOREA
medical schools request books, shipping instructions, 572
request surplus drugs for hospital, especially for tuberculosis, [Codington] 232—C
KVEIM TEST
sarcoidosis diagnosis with, [Israel] 592—ab
KWASHIORKER
lipotropic agents for, (Council report) [Gabuzda] *969
KYPHOSIS: See Spine

L

LABOR: See also "Childbirth" under Medicolegal Abstracts at end of letter M
birth trauma, Brazil, 992
Christian Science vs. hypnotism in, (reply) [Davis] 76—C
induced for irreversible eclampsia, [Falls] *251
natural childbirth; propose teaching mothers by recordings, United Kingdom, 798
presentation, prolapse of arm in, Austria, 1347
spinal anesthesia in vaginal deliveries, [Ehlers] 523—ab
vaginal smear to determine date of, [Lemberg-Siegfried] 82—ab

LABOR UNIONS: See Industrial Trade Unions

LABORATORIES
Army center moved from Tokyo to Camp Zama, (photo) 1156
multipurpose clip from ready-made bow ties, [Hyman] 76—C
simple office procedures for mycology, [Robinson & others] *537

LACTOSE
add to milk-free diet for infant with galactosemia? 341

LAMPHERE, LEO, wandering patient at Camarillo State Hospital, [Chapman] 415—C

LAPAROTOMY: See Abdomen surgery

LARGACTIL: See Chlorpromazine

LARYNX
cancer, epidemiological approach to etiology, [Wynder & others] *1284
edema from chlorpromazine, [Brill] 1355—C
swabs to detect tubercle bacilli in absence of sputum, [Campbell] 708—ab

LATIBON
for rest in acute poliomyelitis, [Brehme] 80—ab

LAVOR, EDWARD MARTIN, missing tuberculosis patient, (photo) [Hirsch] 997—C

LAWLESS, THEODORE K.
Dillard U. dedicates chapel to, Ill., 301

LAWS AND LEGISLATION
Doctor Draft Law: See Medical Preparedness
federal, Jenkins-Keogh bills explained, [Keogh] 1234
federal, progress on mental health Act, guest editorial by Drs. Bartemeier and Appel, 392—E
federal, proposed for mental disorders in Alaska, Dr. Lull writes to Senate on, 1255
federal, social security, [Public Relations] *485; (hearing on H.R. 7225) 1056—E; 1058
federal, Washington Office summary, 878; 1412
food hygiene laws, United Kingdom, 700
legalizing homosexuality advocated, England, 74; (B. M. A. to study) 699
recommend changing abortion law, United Kingdom, 702
state, A.M.A. study of liability, insurance, [Medicine and the Law] *285

LAWYERS: See Attorneys

LAXATIVES: See Cathartics

LE PRINCE, JOSEPH A., dies, 989

LEAD
edathamil calcium-disodium for exposure to, [Manville] 86—ab
poisoning, industrial, relation to climate, [Shiels] 335—ab

LECTURES
Academic Lecture, 1526
Alpha Omega Alpha, 880; 1079
American Gastroenterological Ass'n. Memorial, 125; 1525
Auer (John), 403
Bacon (Charles Sumner), 122
Bauer (Louis H.), 1245
Beattie (Margaret), 2nd, 215
Beaumont, 462
Beck (Harvey Grant) Memorial, 1523
Bedell, 490
Biggs (Hermann M.) Memorial, of New York Academy of Medicine, 303
Brooks (Barney), 304
Brown (Aaron) Lectureship, 302; 784
Carey (Eben J.) Memorial, 1420
Chesley (Albert J.) Memorial, in public health established at U. of Minnesota, 569
Clendening Lectureship, 1418
Danzis (Maximillian) Memorial, established, 570
Drew (Charles R.) Memorial, 1241
Erskine (Arthur), 1418
Finney (John M. T.) Fund, 1523
Fleixner (Abraham) Lectureship, 64
Freeman (Joseph and Samuel), 1420
Friedenwald (Julius) Memorial, 218
Friedlander, 1149
Garrison Memorial, 1339
Gillespie (W. Fulton) Memorial, first, 1341
Golden (Ross), 984
Gordon (Murray B.) Memorial, 1242
Gudakunst (Don W.) Memorial, 983
Harvey Lectures of 1955-56, 123; 490; 882; 1419
Harvey (Samuel C.), 61

LECTURES—Continued
Heiskon (Ludvig) Memorial, 568; 783; (postponed) 1148
Herrick (James B.) Memorial, first, 216
Herzstein (Morris), 782
Horney (Karen), 1079
Kaplan (Ira L.), 1419
Kaplan (Leo A.) Memorial, 1241; 1523
Kober (George M.), 982
Levin (Abraham L.) Memorial, 1245
Lilly, 1340
Linacre, 1473—E
Loeb (Hanau W.) Memorial, 1419
McArthur (Lewis Linn), 1336
Mark (Louise) Memorial, established, 61
Matas (Rudolph), 783
May (Charles H.) Memorial, 882
medical spring series at U. of Virginia, 1150
Menorah Memorial, 1242
Nalle Clinic Foundation, 1337
Nathanson (Morris Henry) Memorial, 982
New York Academy of Medicine, lectures to laity, 63; 303; 490
North Shore Health Resort, 6th annual, 1523
Nu Sigma Nu, 1241
Phi Delta Epsilon, 882; 1079; 1150; 1242; 1335; 1336
Phillips (John) Memorial, 1340
Pollitzer (Siegmund), 983
Rachford (Benjamin Knox), 490
Reisman Memorial, on rheumatic carditis, [Wilson & Lim] *1457
Richmond Academy of General Practice, 1244
Sappington Memorial, 1341
Schoenbach (Emanuel B.) Memorial, 1419
Shmookler (H. B.) Memorial, 571
Sommer Memorial, 1337
Stoneburner, 984
Strauss (Alfred A.), 125
Strauss (Israel), 1242
Trent Memorial, 1339
Tutt (Jack H.) Memorial, 1078
Tufts College Medical School Alumni, 216
Vander Veer (Albert) Memorial, 983
Waksman (Selman A.), 2nd, 684
William (Vincent Park) Memorial, 1078
Wycoff (John), 685
Zeit (F. Robert) Memorial, 1241

LEGAL MEDICINE: See Medical Jurisprudence

LEGS
atherosclerosis in, grafts for, [Horton] 1175—ab
dynamic exercises after amputation in old age, [Ekert] 1266—ab
large fat deposits on, diagnosis and treatment, [184]
lugging for skin traction, [Anderson & Robbins] *1315
pain from thoracic and cervical cord tumors, [Scott] *528
vein grafts in, [Dye] 807—ab
venous congestion, hyaluronidase in, [O'Brien] 712—ab

LEIOMYOSARCOMA
of skin, lymphatic spread, [Levack] 242—ab

LEISURE CORNER: See Physicians, avocations

LENSES
Contact: See Glasses
magnification for submormal vision, [Gordon] 331—ab

LENTICULAR NUCLEUS
blocking of globus pallidus for Parkinsonism, [Narabayashi] 998—ab; [Cooper & others] *1444
degeneration, copper metabolism in, [Bush] 594—ab
degenerative, mobilize copper with dimercaprol and edathamil, United Kingdom, 1353

LEPROSY
Leonard Wood Memorial elects Dr. Karsner chairman, 1156
treatment, chemotherapy, [Doull] 997—ab
treatment, sulfones, India, 75; 993

LEPTOCYTOSIS
hereditary, United Kingdom, 898

LEPTOSPIROSIS
antileptospiral effect of milk, [Kirschner] 417—ab
treatment, penicillin and chloramphenicol fail, United Kingdom, 1089

LERICHE, RENE, died Dec. 29, France, 985; 1253

LEUKEMIA
acute, 6-mercaptopurine for, [Hayhoe] 238—ab
after I^{131} for hyperthyroidism [Pochin] 1180—ab
hazard in atomic energy plants? 151
lymphocytic, CB 1348 for, [Galton] 331—ab
lymphocytic, prednisone and prednisolone for, England, 226; [Nabarro] 239—ab
lymphocytic, sodium radiophosphate for, Austria, 1098
mortality in U. S., 1921-1951 compared with Hodgkin's disease, [Shimkin] 721—ab
myelogenous (chronic), pruritus with, in man 84, 520
Myleran and cortisone effects on nucleic acid in leukemic elements, [Gavosto] 812—ab
research, Tommy Memorial Fund grant to Yale U., 122
rupture of cranial suture by, [Hittig] 84—ab
treatment, status, (Council report) *1228

LEUKOCYTES
count high, normal differential count in asymptomatic man; significance, 250
Döhle bodies in, after burns, [Weiner] 695—ab
in prostatic fluid in chronic prostatitis, [O'Shaughnessy & others] *540; (replies) [Moore; Rosenbloom] 1257—C

LEUKODERMA: See Vitiligo

LEUKOTOMY: See Brain surgery

LEVALLORPHAN
allyhaprodine and, to supplement nitrous oxide-oxygen-thiopental sodium anesthesia, [Foldes & others] *168

LEVOTHYROXINE: See Sodium Levothyroxine

LEVULOSE: See Fructose

LIABILITY: See Malpractice
Insurance: See Insurance, malpractice

LIBEL AND SLANDER
newspaper charged for, by Royal College of Obstetricians and Gynecologists, 1256

LIBRARY
Armed Forces, publication changes; Index-Catalogue closed, [Rogers] 801—C
John Crerar Library receives Harvey's book on circulation from American Heart Ass'n., [Katz] *1137

LICENSURE
A.M.A. Annual Congress (52nd), (program), 34; 120—E; (report) 978
guide to essentials of medical practice act, report at Annual Congress, 978

LIFE
expectancy in papillary thyroid cancer, 89; (replies) [Duffy; Wuester; Lichtenstein] 1269; [Winship; Crile] 1270
expectancy rates, ill., 122

LIGAMENTS
medial collateral, of knee; traumatic calcification, 727
spinal, calcification; an aging process, [Smith] 626—ab

LIGHTING
transilluminators and retractors, [Berens] 159:1532, Dec. 17, 1955; (correction) 160: 492, Feb. 11, 1956

LILLY (ELI) AND COMPANY
Medical Research Fellowship, (South Africa) [Shapiro] 587—C

LIPIDS
metabolism relation to vascular degeneration in diabetes, Switzerland, 1165

LIPIODOL: See Iodized Oil

LIPODYSTROPHY
intestinal, extraintestinal x-ray signs, [Eyler & Doub] *534

LIPOTROPIC FACTORS
in pathogenesis and treatment of fatty liver cirrhosis, (Council article) [Gabuzda] *969

LIVER
abscess (traumatic), aspiration and emetine for, India, 992
cancer etiology, especially in Bantus, [Berman] 804—ab
cancer (metastatic), Au^{198} for; aplastic anemia from, [Schoodman & Schwartz] *461
cancer (metastatic), implant radon seeds for? 727
cells, giant multinucleated, in neonatal hepatitis in siblings, [Krainin & Lapan] *937
cirrhosis, ammonium compounds for; magnesium deficiency after, (Council report) [Flinck] *1106
cirrhosis, chlortetracycline for, [David] 719—ab
cirrhosis, diuretics for, Peru, 134
cirrhosis (fatty), lipotropic agents in pathogenesis and treatment, (Council article) [Gabuzda] *969
cirrhosis, liver extract for, India, 894
cirrhosis, prednisone for, France, 1427
cirrhosis relation to hypertension, [Loyke] 237—ab
cirrhosis with bleeding esophageal varices, emergency treatment, [Linton & Ellis] *1017
cirrhosis with hepatic coma in alcoholics, [Benhamou] 137—ab; (protein nutrition in) (Council report) [Davidson] *290
coma, L-glutamic acid for, [McDermott] 593—ab
damage in infants during labor, sudden shock fatal from, 688
disease from industrial poisoning, [Thompson] 86—ab
disease, managing portal hypertension during surgery for, [Ebeling] 1172—ab
disease, serum aminophenase in, [Kattus & others] *16; [Merrill & others] *1454
dysfunction in fibrocystic pancreas, [di Sant'-Agnese] *846
enzymes in protein malnutrition, India, 794
extract for alcoholism, France, 694
extracts, streptomycin and vitamin B complex for pulmonary tuberculosis, [Pozzi] 1262—ab
function in prostate cancer, [Hudson] 812—ab
function, Swiss gastroenterologists discuss, 1316
function tests correlate with liver biopsy? 519
glycogen disease of, with hepatomata, [Mason] 718—ab

Hepatolenticular Degeneration: See Lenticular Nucleus

LIVER—Continued
histopathology in jaundice from chlorpromazine, [Lindsay] 813—ab
Inflammation: See also Hepatitis, Infectious
Inflammation, blood glutamic oxalacetic aminotherase in, [Weibbrecht & LaDue] *1130
inflammation from carbarsone, [Nelson] *764
inflammation (neonatal) in siblings, with giant multinucleated cells: death from, [Krainin & Lapan] *937
role in water metabolism, Israel, 581
rupture, in newborn infant with recovery, [Greaves] 716—ab
surgery, controlled hepatectomy, France, 133
tests (abnormal) in carriers of viral hepatitis, [Norris & others] *1118
LOAN FUNDS: See also Student, Medical
for 16 medical units by Sears-Roebuck Foundation, 980
LOBOTOMY: See Brain surgery
LONGEVITY: See Life expectancy; Old Age
LORFAN: See Levallorphan
LOS ANGELES COUNTY MEDICAL ASSOCIATION
honored by Michigan for "Medic," (photo) 121
LUCKEY, E. H., of Cornell U, lectures on edema with heart insufficiency, Chile, 786
LUMBOSACRAL REGION
preemployment examinations of, [Divelev & Ogleve] *856
strain in etiology of low back pain, [Divelev & others] *728
LUNGS
abscess, endocavitary aspiration in, [Monaldi] 1367—ab
abscess, operation, France, 1163
calculi, microlithiasis alveolaris, [Kent] 147—ab [Badger] 148—ab
cancer (advanced), nitrogen mustard for, [Hatch & others] *1129
cancer and waterpipe smoking, 248
cancer (bronchiolar), radiotherapy evaluated, England, 73
Cancer (bronchogenic): See Bronchus cancer
cancer, cell types and histology, [Olcott] 333—ab
cancer, epidemiology, New Zealand, 697
cancer etiology, air pollution role, Italy, 1164
cancer etiology relation to larynx cancer, [Wynder & others] *1384
cancer increasing, (Peru) 1253; (United Kingdom) 1430
cancer, industrial aspects, [Breslow] 1096—ab
cancer, inoperable; rotatory irradiation for, [Thoms] 336—ab
cancer (metastatic) with thyroid cancer, [Catz & Starr] *1046
cancer relation to bronchitis, England, 314
cancer, sex-bronchomotic distribution, [Cohart] 722—ab
cavitation diagnosis by auscultation of chest, [Guillaumin] 1258—C
coin lesions, diagnostic significance, [McEachern] 137—ab
collapse (apical), extrapericostal, with plombage, United Kingdom, 1532
congestion, test using Valsalva maneuver, [Knowles & others] *14
consolidation, sign of hypertensive cardiovascular-renal syndrome, [Howes] 1268—ab
edema, acute postoperative; alcohol inhalation in, [Weyl] 149—ab
edema and fibrosis in malignant hypertension during ganglion blocking, [Viersma] 905—ab
edema and fibrosis, prednisone for, Switzerland, 994; (correction) 1341
edema in heart disease and rectum cancer, (Diagnostic Problems) [Frazier] *774; (comment) [Ray] *775
edema in mountain sickness, Peru, 698
Emphysema: See Emphysema, pulmonary
eosinophil infiltration during isoniazid, [Perreau] 147—ab
fibrosis, infection and emphysema; intermittent positive-pressure breathing with bronchodilators for, [Leslie & others] *1125
function, bronchus blockade test for, Austria, 1426
hemorrhage with mitral stenosis, Austria, 312
hemosiderosis in mitral stenosis, [Sacco] 892—ab
Hyaline membrane: See Hyaline Membrane
pathology in fibrocystic pancreas, [di Sant'Agnese] *846
pathology in Hand-Schüller-Christian disease, [McNeil] 986—ab
reactions to dust, Belgium, 1348
sarcoidosis, cortisone for, France, 695
sequestration, preoperative diagnosis by aortography, [Kenney & Eyler] *1464
Surgery: See also Tuberculosis of Lung
surgery, pneumonectomy; flight after, low high; 1184
surgery, resection for bronchial cancer; survival after, United Kingdom, 699
surgery, resection for spontaneous pneumothorax, [Ehrenhaft] 326—ab
surgery, resection in mitral stenosis, [Wallyn] 806—ab
tumors, diagnosis, Brazil, 580
tumors, lymphoma, [Cooley] 909—ab; [van Hazel] 912—ab
LUNGS—Continued
tumors (nodular), planigraphy in differential diagnosis, [Rigler] 335—ab
LUPUS ERYTHEMATOSUS
complications: autoagglutination, 89
discoid, antimalarials for, [Leeper] 1001—ab
disseminated: diagnosis, treatment, research, course of disease, 920
disseminated, hematological diagnosis, [Fallet] 720—ab; [Basset-Lacroniique] 721—ab
L. E. cell as sign of hydralazine toxicity, [Comens & Schroeder] *1134
neurological and psychiatric signs, [Clark & Bailey] *455
profundus, [Arnold] 1001—ab
77 cases, [Marten] 1000—ab
surgical treatment, splenectomy, [Cardozo] 321—ab
treatment, prednisone; Nivaquine, Switzerland, 414
LUPUS VULGARIS: See Tuberculosis luposa
LUTZ, ADOLFO (1855-1940)
centennial, *Revista do Instituto Adolfo Lutz* dedicated to, Brazil, 1161
LYE: See Sodium hydroxide
LYMPH NODES
biopsy, deep cervical and prescalene, [Connar] 324—ab
cervical, in papillary thyroid cancer, [Frazell] 711—ab
enlargement in intestinal lipodystrophy, [Eyler & Dombl *534
invasion practically none in Hodgkin's disease, Brazil, 795
parasternal, in spread and prognosis of breast cancer, [Kaiser] 141—ab
regional, poliomyelitis virus in, [Wenner] 680—ab
LYMPHATIC SYSTEM
caliber of pericardial lymphatic capillaries in piglets, dogs and man, 520
spread of cancer in, [Zeidman] 721—ab
spread of skin leiomyosarcoma in, [Levack] 242—ab
LYMPHEDEMA
after varicosectomy, treatment: hyaluronidase by iontophoresis, (reply) [Funk] 90
LYMPHOBLASTOMA
simulating bone tumors, [Collins & Collins] *1124
LYMPHOGRANULOMATOSIS
treatment, actinomycin C, [Croizat] 681—ab
LYMPHOMA
malignant, *p*-(di-2-chloroethyl-amino)-phenylbutyric acid for, England, 132; [Galton] 331—ab
of lung, [Cooley] 909—ab; (and pleura) [van Hazel] 912—ab
treatment, adrenocortical substances, [Spurr] 591—ab
treatment, nitrogen mustard or TEM; bone marrow depression from, (reply) [Franco] 415—C
treatment, prednisone and prednisolone, England, 226; [Nabarro] 239—ab
LYMPHOSARCOMA
treatment, actinomycin C, [Croizat] 681—ab
d-LYSERGIC ACID DIETHYLAMIDE
mental disorders and, United Kingdom, 1353
LYSOZYME
in etiology of peptic ulcer, Austria, 1251

M

MACULA LUTEA
edema with retinitis, recurrent; heredomacular degeneration vs. central serous retinopathy, (reply) [Gordon] 610
MAGAZINES: See Journals
MAGNESIUM
deficiency syndrome, (Council report) [Flink] *1406
MAGNIFYING LENS: See Lenses
MALARIA
control program by WHO, 1254
eradication in Southeastern Europe, 500
extension of 5-year control plan, India, 686
falciparum, India, 893
for nephrotic syndrome, [Gilbertsen & Basshour] *25; [Gairdner] 329—ab
MALPRACTICE: See also Medical Jurisprudence; Medicolegal Abstracts at end of letter M
boy awarded damages for injection against his will, England, 314
Committee: See Societies, Medical
Insurance: See Insurance, malpractice
surgeon's responsibility after paralysis from injection by nun, France, 1163
wrong finger amputated, patient awarded damages, United Kingdom, 701
MALROSINOL
tests and standards, 1055
MARCOUMAR: See 3-(1-Phenylpropyl)-4-Hydroxycoumarin
MAREZINE: See Cyclizine
MARRIAGE
conflicts, birth control in, Switzerland, 1530
interclass, United Kingdom, 897
MARTYRS
Dr. B. Epstein killed in line of duty, Chicago, 1148
MASKS
for mothers while feeding infants? 1438
necessary to cover nose in surgery? 424
MASSACHUSETTS GENERAL HOSPITAL
cardiac arrest during surgery in, 1925-1954, [Briggs & others] *1439
MASSAGE
for rheumatoid arthritis, [Rae & Bender] *811
MASTER Two-Step Test: See Heart function
MASTITIS: See under Breast
MASTOIDECTOMY
modified radical, in chronic attic and middle ear disease, [Duers] *451
MASTOIDITIS
tuberculous, medical therapy, Austria, 794
MASTURBATION
in girl 18 months old, treatment, 519
MATERNITY
care in Grand Rapids, Michigan, (Council article) *1072
instructions for postpartum patients, 816
mortality from eclampsia reduced, [Falls] *251; (reply) [Allen] 997—C
mortality study, Franklin County, Ohio, (Council article) *296
MEAT
inspect for trichinosis, practical method? 341
tenderizing harmful: Hormones for capons or antibiotics for animals dangerous? 1004
MECHLORETHAMINE
to prevent cancer in animals, Austria, 794
MECLIZINE HYDROCHLORIDE
to prevent motion sickness aboard transport ships, *755; (correction) 1004
treatment of nausea and vomiting in pregnancy, [Lebherz] 420—ab
MECONIUM
ileus in fibrocystic pancreas, [di Sant'Agnese] *846
MEDIASTINUM
upper, fluid level in, from esophagus stenosis, [Catalano & Levin] 1533—C
Medical . . . . For most entries see under the noun concerned as Economics, Medical; Education, Medical; Journals; Schools, Medical, etc.
MEDICAL CENTER: See also Health center
program at New York U.-Bellevue Medical Center evaluated, 785
MEDICAL CERTIFICATES
for police, abuse of, Sweden, 1165
MEDICAL COUNCIL OF INDIA discusses medical education, 797
MEDICAL DAYS
cancer days, (Genesee County, Mich.) 1242; (Brooklyn; Mich.) 1419
clinic days, (U. of Buffalo alumni) 1079; (Northern Virginia) 1244; (Internat. College of Surgeons' European) 1422
postgraduate days, (Johns Hopkins) 402; (Roanoke Memorial Hospital) 984
Rheumatological Roman Days, 4th, 66
World Health Day, April 7, 1151
MEDICAL EXAMINATION: See Physical Examination
MEDICAL JURISPRUDENCE: See also Malpractice; Medicine and the Law; Medicolegal Abstracts at end of letter M
abuse of medical certificates, Sweden, 1165
alleged neglect of fractured ribs, liability committee studied, Sweden, 413
A.M.A. Board authorizes legal counsel meeting, 1322
Boston U. School of Law lectures on personal injury, 489
compensation for hysteria after railway accident, United Kingdom, 502
Dr. Cantor, member of the District of Columbia bar, 102
Institute of Forensic Medicine of Hadassah Medical School opened, 582
Journal of Forensic Sciences, first issue, Jan. 1, 161
ligitation involving N.H.S. physician's alleged refusal to treat patient, England, 133
medicolegal office evaluated, autopsy index as comparative standard (replies) [Turkel] 503—C; [Schaefer] 587—C
naturopath criticized, patient died on diet for rheumatism, United Kingdom, 1352
out-of-state doctor writing prescriptions legal? 616
pathology and radiology practiced by Iowa hospitals illegal, 53—E; [Medicine and the Law] 58
physician-attorney relationship, [Medicine and the Law] *1415
press exchanged opinions on patient complaints, Sweden, 896
unethical conduct charged against Dr. Kelvin, United Kingdom, 897
MEDICAL MISSIONARIES
foreign training center for native workers, [Garoche] 502—C
MEDICAL PRACTICE: See Medicine, practice; Physicians
MEDICAL PRACTICE ACTS: See Licensure; Medicolegal Abstracts at end of letter M
MEDICAL PREPAREDNESS
A.M.A. information on, 1413
civilian doctor and security, problems of military service, (reply) [Hahn & Raffensperger] 899—C
physicians liable for military duty, 495

MEDICAL RECORDS
Joint Commission on Accreditation of Hospitals' standards, 294
ownership, patient removed hers, United Kingdom, 898
MEDICAL RESEARCH COUNCIL (England)
report on oil and saline adjuvants in influenza vaccines, 132; [Stuart-Harris] 321—ab
MEDICAL SERVICE
Emergency Medical Service: See Emergency
for Indigent: See Medically Indigent
for mental disorders in Alaska, Dr. Lull writes to Senate on proposed law, 1235
mobile medical support for civil defense, [Olson & others] *1202; [Howard & others] *1211
plans, Canada, 1087
plans, Social Welfare vs. Peruvian Medical Ass'n. on, 1164
MEDICAL SOCIETY: See Societies, Medical; list of Societies at end of letter S
MEDICAL SPECIALISTS: See Specialists
MEDICALLY INDIGENT
centers of public assistance, Colombia, 1162
family help service, Kent County recommends continuing, England, 73
free services extended, Ireland, 1253
free treatment for tuberculosis, India, 993
propose state program, Mo., 302
MEDICINE
academic and practice, filling the gap, [Stone] *1298
atomic, navy correspondence course in, 129
heart, progress, and vision, [McDaniel] *1193
history, discoveries by students, [Carter & Luckhardt] 504—C
history, early surgical professorships, [Ascher] 415—C
history, European museums, [Stenn] 1090—C
history, U. of Buffalo to teach, 63
Legal: See Medical Jurisprudence
practice, establishing: Sears-Roebuck Foundation guide, [Business Practice] *233; *319; *504; *589; *900; *1356; (loans for) 980
practice, general: in Scotland, 132
practice, general, psychiatric diagnosis in, [Caveny] 509—ab
practice, trends in specialization of American graduates, [Weiskotten] *1303
practice, unverifiable hypothesis: what would have happened if therapy differed? 563—E
radioactive isotopes in, Austria, 1086
reintegration of, 1472—E
religion's role in, [Blanton] 1355—C
why they studied medicine; autobiographies, [Leisure Corner] *77
MEDICINE AND THE LAW
Committees for Review of Medicolegal Testimony, A.M.A. survey, *1334
Court holds Iowa hospitals engaged in illegal medical practice, *58
income tax deduction of postgraduate courses expense, *399
physician-attorney relationship, *1415
professional liability insurance and prevention program, *395
tissue committee in hospital accreditation, *1238
MEDICOLEGAL: See Medical Jurisprudence; Medicine and the Law; Medicolegal Abstracts at end of letter M
MEGACOLON: See Colon
MEGAESOPHAGUS: See Esophagus dilatation
MEGIMIDE: See β,β-Methylethylglutarimide
MELANOMA (melanosarcoma)
tyrosine tagged with C^{14} to study, Switzerland, 414
MEMORY LOSS: See Aphasia
MEN
breast cancer in, India, 1163
fatal gangrenous cholecystitis and peritonitis after unrelated surgery more common in, [Levin] *1040
infertility, testosterone for, [Charny] *98
infertility: treatment, prevention, research, [Tyler & Singher] *91
MÉNIÈRE'S DISEASE: See Vertigo, aural
MENINGES
subdural hematoma, angiographic diagnosis, Brazil, 312
subdural hematoma (traumatic), exploratory trephination in, Switzerland, 1165
subdural hemorrhage in old age, [Moore] 913—ab
MENINGIOMA
parasagittal, [Hoessly] 808—ab
MENINGITIS
coccidioidal, complement fixation antibodies in spinal fluid in, [Smith & others] *546
from Mima organisms, 1183
purulent, treatment, [Aarsvold] 1285—ab
tuberculous, corticotherapy, [Boudin] 1282—ab
tuberculous, pulmonary eosinophilia during isoniazid in, [Perreau] 147—ab
tuberculous, pulmonary miliary tuberculosis with; prognosis, [De Angelis] 716—ab
tuberculous, streptomycin-isoniazid-hydrocortisone for, [Cocchi] 1000—ab
tuberculous, streptomycin plus isoniazid for, United Kingdom, 1254
MENOPAUSE
vasomotor instability in, pituitary effect on, [Hellbaum] 999—ab
MENSTRUATION
ovulation rare after last, contraceptives unnecessary, 152; (advise use for 2 years) [Calderone] 1100
premenstrual eczema, treatment, 341; (reply) [Greenblatt] 1186
skin diseases during, vitamin E for, Switzerland, 995
MENTAL DEFECTIVES
care, centenary of progress, Denmark, 499
cerebral palsied, zoxazolamine in, [Abrahamsen & Baird] *749
children's clinics opened, (at U. of Rochester) 570; (at U. of Washington) 571
phenylpyruvic oligophrenia, [Schönenberg]; (electroencephalogram in) [Fois] 914—ab
phenylpyruvic oligophrenia, phenylalanine-free hydrolyst and glutamic acid for? 83; (reply) [Glaser] 922
rubella as cause, [Kirman] 420—ab
treatment, Rauwolfia, Denmark, 500; [Jensen] 913—ab
upbringing and, United Kingdom, 584
vocational rehabilitation for, N. J., 403
MENTAL DEPRESSION
etiology: Rauwolfia, France, 581
treatment, chlorpromazine and reserpine, [Zeller & others] *179
MENTAL DISORDERS
diagnosis in general practice, [Caveny] 509—ab
etiology in old age, [Busse] 242—ab
Hospitalization for: See Hospitals, mental
in Alaska, Dr. Lull writes to U. S. Senate on proposed law on, 1235
in intractabe ulcerative colitis, prefrontal lobotomy for, [Levy & others] *1277
in lupus erythematosus, [Clark & Bailey] *455
Joint Commission on: See Joint Commission
lysergic acid diethylamide and, United Kingdom, 1353
senile agitation, chlorpromazine for, [Settel] 808—ab; [Terman] 1176—ab
treatment: chlorpromazine, reserpine, isoniazid, [Hewat] 143—ab
treatment, dangers of Rauwolfia or chlorpromazine with electric shock, (reply) [Epstein] 503—C
treatment, electric shock; peroneal paralysis after, [Karliner] 586—C
treatment, electric shock: problems in use, 339
treatment, Rauwolfia, [Torsegno] 512—ab; (and chlorpromazine, Italy) 697
urine copper-reducing steroid in, [Merivale] 599—ab
VA program for long-term patients, 309
MENTAL HEALTH
Campaign in May, 1339
conference of 10 northeastern states, 1080
exhibits, England, 228
Joint Commission on: See Joint Commission
legislative session on, televised, W. Va., 785
Mental Health Week, Ill., 1523
plays on family problems available, Mich., 881
statistics, Canada, 1088
television program, March 18, 786
MENTAL TENSION
from jejunal and duodenal diverticula? 520
MENTAL TESTS: See Intelligence tests
MEPACRINE: See Quinacrine
MEPERIDINE
continuous drip, as adjunct to thiopental sodium-nitrous oxide-oxygen, [Ausherman & others] *175
treatment of cough, United Kingdom, 1429
MEPHENESIN
carbamate, N.N.R., 289
chlorpromazine with, vs. zoxazolamine as muscle relaxant, [Amols] *742
MEPROBAMATE
habituation, [Lemere] 1431—C
N.N.R., 1405
MERALLURIDE
weight loss in healthy subject from; how much suggests pathology? 423
MERATRAN: See Pipradrol
MERCAPTOARSENOL: See Arsthinol
*di*MERCAPTOPROPANOL: See Dimercaprol
6-MERCAPTOPURINE
treatment of leukemia, [Hayhoe] 238—ab; (current status) (Council report) *1228
MERCUHYDRIN: See Meralluride
MERCURY
chloride effect on poliomyelitis virus excretion after oral immunization, [Koprowski & others] *954
conference on, N. Y., 1149
MESTINON: See Pyridostigmine
METABOLISM
disorders simulating bone tumors, [Collins & Collins] *431
metabolic unit in genito-urinary hospital, United Kingdom, 1256
neonatal, and kidney function, Austria, 1161
triiodothyronine effects on, [Frawley & others] *646
METACORTANDRACIN: See Prednisone
METACORTANDRALONE: See Prednisolone
METHADONE HYDROCHLORIDE
treatment of cough, United Kingdom, 1429
METHAMPHETAMINE HYDROCHLORIDE
treatment plus Dilantin and phenobarbital in epilepsy, [Davidson & Berman] *766
METHIONINE
in pathogenesis and treatment of fatty liver cirrhosis, (Council article) [Gabuzda] *969
METHIUM: See Hexamethonium
METHONIUM
Hexamethonium: See Hexamethonium
type of ganglion-block for severe hypertension, [Bauer] 418—ab
METHYL ALCOHOL
poisoning in sailors, Canada, 1088
METHYL BROMIDE
poisoning, France, 1163
METHYL PHENYLPIPERIDYLACETATE
treatment of senile behavior, [Ferguson & Funderburk] *259
METHYL TESTOSTERONE: See Androgens
ββ-METHYLETHYLGLUTARIMIDE
barbiturate antagonist, [Shaw] 720—ab
METHYLPENTYNOL
toxicity, psychosis, England, 159:1232, Nov. 19, 1955; (correction) 160:787, March 3, 1956
METHYLPHENYL HYDANTOIN
toxicity: aplastic anemia fatal, [Isaacson & others] *1311
METICORTEN: See Prednisone
METOQUIN: See Quinacrine
MICHIGAN
maternal and child care in Grand Rapids, (Council article) *1072
State Medical Society honors Los Angeles ass'n. for "Medic," (photo) 121
MICROCOCCUS: See Staphylococcus
MICROGNATHIA
glossoptosis with, [Jaso] 811—ab
MICROLITHIASIS: See Lungs calculi
MICROSCOPY
electron, of atheroma, United Kingdom, 585; [Levene] 721—ab
MICROWAVES
biophysical basis for use of, [Schwan] *191
MIGRAINE
diagnosis of periodic headache in girl 8? 1185
MILITARY
medicine and dentistry developments, symposium, 691
medicine (preventive) course, 1527
Preparedness: See Medical Preparedness
MILK
antacid quality compared to Sustagen, [Winkelstein & Schweiger] *1111
antileptospiral effect, [Kirschner] 417—ab
diphtheria from, Indiana, 1078
drip for gastric ulcer, United Kingdom, 1255; [Doll] 1365—ab
free-diet for infant with galactosemia, add lactose? 341
powder, poisoning from, United Kingdom, 1430
sanitary code amended on brucellosis-free cows, N. Y., 123
MILONTIN: See Phensuximide
MILTOWN: See Meprobamate
MIMA ORGANISMS, infections due to, 1183
MIOKON SODIUM: See Diprotrizoate
MISSING PERSONS
Lamphere (Leo), wandering patient now at Camarillo State Hospital, [Chapman] 415—C
Lavor (Edward Martin), tuberculosis patient, (photo) [Hirsch] 997—C
MISSIONARIES: See Medical Missionaries
MITES
from pigeons cause skin rash, (reply) [Burgess] 1186
MITRAL VALVE
insufficiency, circumferential suture of mitral ring for, [Davila] 140—ab
stenosis, anticoagulants to prevent embolism in, [Varela de Seijas Aguilar] 591—ab
stenosis during pregnancy, surgery for, Switzerland, 1350
stenosis, pulmonary resection for, [Wallyn] 806—ab
stenosis, recurrence, reintervention for, [Morino] 710—ab
stenosis with lung hemorrhage, Austria, 312
stenosis with pulmonary hemosiderosis, [Sacco] 802—ab
surgery, commissurotomy results, (subjective and objective) [Bergy] 239—ab; (factors influencing) [Milnor] 1262—ab
surgery, cortisone effect on rheumatic lesions after, [Gil] 240—ab
surgery: physical, radiologic, and electrocardiogram changes, [Otto] 510—ab
surgery, valvotomy results after 3 or more years, England, 228
surgery, valvulotomy, staphylococcal endocarditis after, [Dalton] 1366—ab
MÖRCH RESPIRATOR for uncuffed tracheostomy tube, [Mörch & others] *864
MOHR, Philip E., director of A.M.A. Directory-Biographical Department, 879
MOLE: See Nevus
MONAGHAN POSITIVE-PRESSURE ATTACHMENT for respiration via uncuffed tracheostomy tube, [Mörch & others] *864

MONILIASIS
treatment, Mycostatin intravenously, **159**: 1982, Dec. 31, 1955; (corrections: severe reactions from intravenous method) **160**: 220, Jan. 21, 1956
MONOXYCHLOROSENE
treatment of tuberculous bladder ulcers, [Latzimer & others] *544
MONTEGGIA FRACTURES
[Mobley] 142—ab
MONTGOMERY TUBERCLE
mastitis (acute) from, [Gunther] 1434—ab
MORINDA
citrifolia root for hypertension, France, 133; [Dang Van Ho] 146—ab
MORPHINE
heroin, manufacture in England banned, (Fellowship for Freedom in Medicine discusses) 226; (supply problem and substitutes) 314; (ban lifted) 502
poisoning incidence, Denmark, 1162
treatment of cough, United Kingdom, 1429
treatment plus amiphenazole for pain of terminal cancer, United Kingdom, 1351
"MOTH-BALL" potatoes from insecticides, England, 74
MOTION PICTURES: See Moving Pictures
MOTION SICKNESS
prevention aboard transport ships, drugs evaluated, *725; (correction) 1081
MOTORCYCLES
accidents, emphysema of face, neck, and thorax after face fractures, [Heslop] 210—ab
MOUNTAIN SICKNESS: See Altitude, high
MOUTH
dry, after abdominal vagotomy, [Rowntree] 1258—C
Italian Congress on Stomatology, 133
MOVING PICTURES
A.M.A. forms Physicians' Advisory Committee, 1147, 1322
available to A.M.A. members, [Public Relations] *59
ceiling projectors for shut-ins from Buffalo Consistory, 784
photography, [Leisure Corner] *1259
program at A.M.A. Chicago Meeting, 1506
Reviews of Medical Motion Pictures available, 981
"Thoraco-Abdominal Nephrectomy" available in Arkansas, 401
MOVING PICTURES, MEDICAL (REVIEWS)
Baby Goes Home, 1364
Bronchopulmonary Segments, 416
Cancer Detection, 1093
Cancer of the Oral Cavity, 1093
Community Health and You, 704
Food for Freddy, 590
Fractures of the Forearm, 900
Health and Safety for You Series, 704
Invaders, 136
Linear Accelerator, 1364
Local Anesthesia with Cyclaine in Hospital Practice, 704
Local Anesthesia with Cyclaine in Office and Clinic Practice, 704
Miracle of Reproduction, 1093
Myasthenia Gravis: Diagnosis, Treatment and Management, 1364
Parasite and the Mosquito, 1093
Parents Are People Too, 704
Place for Courage, 78
Positive Approach to the Psychiatric Patient, 590
Principles of Ultrasonics, 590
Psychological Aspects of Cancer, 704
Pump Trouble, 78
Sniffles and Sneezes, 704
Someone Who Cares, 1364
Surgical Correction of Interventricular Defects Employing Controlled Cross Circulation, Part III, 1093
Too Young to Say, 136
Upper Extremity Prosthetic Principles, 1093
What About Drinking, 1093
Your Body During Adolescence, 704
MUCOUS MEMBRANES
polyps and pigment in Peutz-Jeghers syndrome, [Freeman] 327—ab
MUCOVISCIDOSIS
found in diagnosing asthma, [Howes] 1260—ab
MUNCHAUSEN SYNDROME
patients invent symptoms for hospital treatment, England, 226
wandering patient, Leo Lamphere, [Chapman] 415—C
MUNITIONS
Tetryl: detonating agent vs. propellant, [Schaefer] 586—ab
MURDER
Hunterian Society debates capital punishment for, England, 413
MURRAY, DWIGHT H.
president-elect of A.M.A., portrait, preceding 1439
MUSCLES
biophysical basis of physical medicine, [Schwan] *191
disease diagnosis especially by electric current, (reply) [Licht] 76—C
MUSCLES—Continued
forceps for ptosis and superior oblique surgery, [Berens] *207
hypertrophy can cause large fat deposits on legs, 1184
Inflammation (Multiple): See Dermatomyositis
necrosis, blood aminopherase in, [Merrill & others] *1454
pathology and psychological test, Italy, 1164
relaxant: zoxazolamine, [Amols] *742; (in rheumatic diseases) [Smith & others] *745; (in cerebral palsy) [Abrahamsen & Baird] *749; (in spasticity) [Rodriguez-Gomez & others] *752
relaxants for rheumatoid arthritis† 1099
relaxants in anesthesia, United Kingdom, 700
rigidity in Parkinsonism, (ethoptopazine hydrochloride improves) [Doshay & others] *248; (quantitative measurement) [Agate & others] *252
Sarcocystis in man, India, 75
tremor in magnesium deficiency syndrome, (Council report) [Flink] *1406
MUSEUMS
European, of interest to Americans, [Stiens] 1050—C
MUSHROOMS
reliable test for edibility† 1438
MUSIC: See Physicians, avocations
MUSTARD
Gas: See dChloroethyl Sulfide
Nitrogen: See Nitrogen Mustard
MUSTARGEN: See Mechlorethamine
MYANESIN: See Mesbenesin
MYASTHENIA GRAVIS
diagnosis with edrophonium chloride, [Osserman & Teng] *153
surgical treatment, thymectomy status, [Eaton] 141—ab
treatment, ambenonium chloride, [Westerberg] 998—ab
treatment, pyridostigmine bromide, [Tether] *156
MYCOLOGY
simple office diagnosis, [Robinson & others] *537
MYCOSIS
fungoides, CB 1348 for, [Galton] 331—ab
fungoides followed for 14 years in Dr. Cannon, [Ash] 333—ab
MYCOSTATIN: See Nystatin
MYELOGRAPHY: See Spinal Canal
MYELOMA
multiple, bone pain with, treatment, 1374
MYELOPATHY
from cervical spondylosis, diagnosis, treatment, [Northfield] 889—ab
MYLERAN: See Busulfan
MYOCARDITIS
in newborn infants from Coxsackie B virus, [Javett] 810—ab
MYOCARDIUM
infarction, anticoagulants for, [Manson] 802—ab; (Austria) 1426
infarction, appendectomy after; anesthesia for, (reply) [Baldwin] 728
infarction, blood aminopherase in diagnosis, [Kattus & others] *16; (and C-reactive protein) [Goldner] 591—ab
infarction, electrocardiogram one year after, [Gittler] 1094—ab
infarction from arterial calcification in infants, [Traisman] 915—ab
infarction, juvenile, France, 1427
infarction relation to coronary occlusion, [Snow] 245—ab
infarction, syndrome resembling benign pericarditis after, [Dressler] *1379
infarction, 10-year prognosis, [Weiss] 902—ab
revascularize by mammary artery ligation after infarction, (anesthesia for) [Muzzulini] 149—ab; [Battezzati] 713—ab
MYOPIA
bifocal lenses in prepresbyopic ages, 90
MYOSITIS
Multiple: See Dermatomyositis
ossificans simulating bone tumors, [Collins & Collins] *1131
rheumatoid, zoxazolamine in, [Smith & others] *745
MYSURAN: See Ambenonium Chloride
MYXEDEMA
primary, from postpartum shock, United Kingdom, 502
treatment, triiodothyronine, [Frawley & others] *646
MYXOMATOSIS
from rabbit fleas, United Kingdom, 1353

Medicolegal Abstracts

ABANDONMENT OF PATIENT
malpractice in relation to, 1170
ACCIDENTAL DEATH
compensability, 588
BENZEDRINE
injury following ingestion of benzedrine and cocacola, 588
BLOOD
coagulant; death following injection of, 588

Medicolegal Abstracts—Continued
CEREBRAL HEMORRHAGE
WC in relation to, 588
CHILDBIRTH
abandonment, 1170
HOSPITALS, CHARITABLE
immunity of trust funds, 588
insurance, indemnity; as affecting liability, 588
liability in general, 588
INSURANCE, ACCIDENT
anaphylactic reaction to neohemoplastin, 588
blood coagulant; death following injection of, 588
injection; death following, 588
neohemoplastin; death following injection of, 588
INSURANCE, INDEMNITY
charitable hospitals; liability as affected by, 588
MALPRACTICE
abandonment of patient, 1170
burns; roentgen rays, 1170
calls; failure to respond, 1170
childbirth; abandonment of patient, 1170
limitation of actions; accrual of right of action, 1170
roentgen rays; burns, 1170
MEDICAL PRACTICE ACTS
licenses; revocation; causes in general, 586
licenses; revocation; contempt of Congress, 1170
licenses; revocation; crime committee in another state, 1170
licenses; revocation; evidence justifying, 586
licenses; revocation; incompetent conduct, 586
licenses; revocation; unprofessional conduct, 586
naturopathy; as practice of medicine, 319
naturopathy; need for medical license, 319
NATUROPATHY
as practice of medicine, 319
need for medical license, 319
NEOHEMOPLASTIN
death following injection of, 588
WORDS AND PHRASES
accidental death, 588
incompetent conduct, 586
unprofessional conduct, 586
WORKMEN'S COMPENSATION ACTS
accident, 588
cerebral hemorrhage, 588
coca-cola and benzedrine; injury following ingestion, 588
compulsory surgery, 1170
knee injury; right to require employee to undergo surgery, 1170
semilunar cartilage; remedial surgery; employee's refusal to undergo, 1170
surgery; refusal of employee to undergo, 1170

N

NAILS (anatomic)
capillary microscopy of nailbed in rheumatic fever, [Davis] 709—ab
hemorrhages at periphery, cause† 921
ingrown, remove matrix and treat base with chemical, (reply) [Wirth] *818
NARCOSIS: See Anesthesia; Hibernation, Artificial; Sleep therapy
NARCOTICS: See also Drugs
addiction, Illinois research grant to Northwestern U., 683
NATIONAL (societies): See also Societies at end of letter S
Advisory Allergy and Infectious Diseases Council announced by surgeon general, 989
Assizes of Medicine meeting, Paris, 1349
Association Against Tuberculosis extends to other diseases, Sweden, 698
Blood Transfusion Service, report, United Kingdom, 700
Conference on Rural Health, 11th, program, 394
Congress of Industrial Medicine, Italy, 1164
Formulary Advisory Panel, A.M.A. members on, 1323
Fund for Medical Education originated Medical Education Week, 1110—E
Hospital Week emphasizes disaster planning, 976—E
Institute of Allergy and Infectious Diseases, established, 576; 1423
Institute of Hygiene and Public Health reorganized, Peru, 698
Medical Defense Conference: See Civilian Defense
Opinion Research Center, doctors look at cancer program, [Miscellany] *1171
Research Council, Food Protection Committee study of artificial sweeteners, (Council statement) *875
Safety Council, (uncovers freak accidents) [Jones] *318; (President's Medal to Capt. Shone) 1342
Science Foundation grants, 1342
NATIONAL HEALTH SERVICE (England)
ambulance service problems, 1429
cost increased by sales tax increase, 798
cost rising from growing staffs, 1049
costs, Guillebaud report, 996

NATIONAL HEALTH SERVICE—Continued
cuts, recommend to Parliament, 227
home consultation fees by specialists in, 227
litigation involving physician's alleged refusal to treat patient, 133
regional prescription cost variations, 1256
vs. private treatment, Fellowship for Freedom in Medicine discusses, 228
NATUROPATHY: See also Medicolegal Abstracts at end of letter M
naturopath criticized for rheumatism diet, patient died, United Kingdom, 1352
NAUSEA
of pregnancy, Bonamine for [Lebherz] 420—ab
of pregnancy, current therapy, (Council report) •208
postanesthetic: dimenhydrinate, chlorpromazine, and pentobarbital sodium for, [Knapp & Beecher] •376
NAVY, UNITED STATES
recruits, benzathine penicillin G for streptococci carriers, [Brooks & Mac] •162
NECK
dissection for papillary thyroid cancer? 89; (replies) [Duffy; Wuester; Lichtenstein] 1269; [Winship; Crile] 1270
emphysema after face bones fractures, [Heslop] 240—ab
manipulation causes basilar thrombosis with softenings in cerebellum and brain stem, [Ford] 1264—ab
NECROPSIES: See Autopsies
NEEDLES
fear of, in otherwise normal woman, 1100
NEEDY: See Medically Indigent
NEGROES
cholelithiasis in, [Cunningham] 813—ab
Christmas disease in, [Golding] 418—ab
liver cancer etiology in Bantus, [Berman] 891—ab
pernicious anemia in Bantus, [Woods] 885—ab
sickle-cell anemia signs in children, [Scott] 661—ab
NEMBUTAL: See Pentobarbital Sodium
NEOHEMOPLASTIN: See Medicolegal Abstracts at end of letter M
NEOMERCAZOLE: See Carbimazole
NEOMYCIN
bacterial resistance, serial subculture in mixtures effects, [Molomut & others] •967
toxicity: dermatitis, skin tests negative, [Epstein] 1355—C
toxicity: nephropathy, [Powell & Hooker] •357
NEPHRITIS
chronic, anuria in, [Vallery-Radot] 811—ab
epidemic acute, [Stetson] 707—ab
glomerular, Switzerland, 1428
infectious, and streptococci, [Wahl] 145—ab
Tuberculous: See Kidneys, tuberculosis
NEPHROBLASTOMA
in children, United Kingdom, 1430
NEPHRON Nephrosis: See Kidneys, disease
NEPHROSIS; Nephrotic Syndrome: See Kidneys, disease
NEPRESOL: See Dihydrazinophthalazine
NERVES
Auriculotemporal regenerated, gustatory sweating from misdirection of, [Gardner & McCubbin] •272
laryngeal recurrent, vulnerability at thyroidectomy, [Wade] 713—ab
median or ulnar, problems could cause numb hands at night, (replies) [Ehni; Stephens & Welch] 922
neurolytic agents injected into globus pallidus for Parkinsonism, [Cooper & others] •1441
peripheral, lesions of, during coma, [Olsen] •39
peroneal paralysis, after electric shock, [Katzner] 586—C
splanchnicectomy (lumbodorsal) for hypertensive vascular disease, [Smithwick & others] •1023
vagal stimulation effect on cardiac arrhythmia, [Jacoby] 516—ab
vagotomy (abdominal), dry mouth following, [Rowntree] 1258—C
vagotomy for duodenal ulcer, [Zollinger & Williams] •367
NERVOUS SYSTEM
amyloid polyneuropathy, [Sullivan] 601—ab
complications from spinal anesthesia, Peru, 895
corticostriospinal degeneration in presenile dementia, [Bornstein] 600—ab
disease diagnosis especially with electric current, (reply) [Licht] 76—C
electric shocks effect on, 817
involvement likely in episodes of collapse with cyanosis in diabetic woman, 689
neurothyroid concept of Rasedow's disease, [Klotz] 137—ab
neurovegetative syndrome, visceral vasodilation in, Switzerland, 1253
nicotine effect on, United Kingdom, 585
pathology in gas gangrene, Brazil, 1161
Rauwolfia effects on, [Lewis & others] •822
signs of Behcet's syndrome, [Pallis] 1370—ab
NERVOUS SYSTEM—Continued
signs of polycythemia vera, Brazil, 313; 1427
signs of systemic lupus erythematosus, [Clark & Bailey] •455
Sphenothalamic section for breast cancer pain, [French] 916—ab
NERVOUS SYSTEM, SYMPATHETIC
block in apoplexy, [de Takats] 80—ab
block (stellate), anterior approach, [Moore & Brindenbaugh] •138
complications in hypertension, Morinda citrifolia for, [Dang Van Ho] 146—ab
NERVOUS TENSION: See Mental Tension
NEURALGIA
trigeminal, stilbamidine for, (reply) [Smith & Miller] 1431—C
trigeminal, surgery in old age for, Italy, 133
NEURITIS
peripheral, during coma, [Olsen] •39
NEURODERMATITIS
treatment, prednisone, [Feinberg & Feinberg] •264
NEUROMA
acoustic, disability after removal, rehabilitation for, 340
NEUROSIS
treatment, chlorpromazine and reserpine, [Zeller & others] •179
NEUROSURGERY
diphenylhydantoin sodium for postoperative convulsions, [Murphy & Schwab] •385
NEUROSYPHILIS
diagnosis, Treponema pallidum immobilization of spinal fluid, [Miller & others] •1394
treatment, United Kingdom, 1254
NEUTROPENIA
thymus tumors with, (Diagnostic Problems) [Ramos] •1317; (comment) [Loeb] •1319
NEVUS
capillary, P32 for, [Roe] 421—ab
flammeus, treatment indicated after beta-rays, 1100
NEW YORK UNIVERSITY
prosthetics rehabilitation course, 685
NEWSPAPERS: See Press
NIADRIN: See Isoniazid
NICOTINALDEHYDE THIOSEMICARBAZONE
treatment plus isoniazid in tuberculosis, Ireland, 1253
NICOTINE
effect on nervous system, United Kingdom, 585
hydration with, for congestive heart failure; water excretion after, [Hanenson] 1432—ab
NICOZIDE: See Isoniazid
NISENTIL: See Alphaprodine Hydrochloride
NITRITES
for angina, glaucoma contraindication to? 1000
NITROFURANTOIN
treatment of urinary infections, [Stewart & Rowe] •1221
NITROFURAZONE
treatment of ingrown toenail after removing margin, (reply) [Wirth] 818
treatment of testicular cancer metastases, [Widenmuth] 146—ab
NITROGEN
metabolism, effect of blood loss and transfusion after trauma, [Fleur] 419—ab
NITROGEN MUSTARD
toxicity: hematopoietic depression, (reply) [Franco] 415—C
treatment of advanced lung cancer, [Hatch & others] •1129
treatment of alcohol sensitivity in Hodgkin's disease, [Godden & others] •1274
treatment status in leukemias, (Council report) •1228
NITROUS OXIDE
ether with, for cesarean sections, [McNally & Fitzpatrick] •1005
oxygen-thiopental sodium anesthesia, (levallorphan and alphaprodine with) [Foldes & others] •168; (meperidine with) [Ausherman & others] •175
thiopental with, for minor procedures? 518
NIVAQUINE: See Chloroquine
NOCARDIOSIS
bacteriology and pathology, [Weed] 805—ab
NOMENCLATURE: See Terminology
NORTHWESTERN UNIVERSITY
new research laboratories to study lungs, heart, kidneys and blood vessels, 82
research on narcotic addiction, 683
NOSE
absorption of vitamin B12 in pernicious anemia, [Monto] 137—ab
discharge in the newborn after mother received reserpine, [Finnerty] 997—C; [Rogers] 1090—C
hospital staphylococcus carrier state, [Brodie] 901—ab
lavage, air embolism after, [Thomson] 719—ab
necessary to cover with surgical mask? 424
polyps, prevent recurrences with deep therapy and/or irradiation? 250
submucous resection after injury with cerebrospinal rhinorrhea, how long wait? 151
NOVOEMBICHIN
treatment of Hodgkin's disease, United Kingdom, 1429
NUCLEAR: See Atomic Energy
NUCLEIC ACID
in leukemic elements, Myleran and cortisone effects on, [Gavosto] 812—ab
NUFFIELD
Foundation research grants, 584
Orthopedic Center to study crippling diseases and injuries, 788
NUMBNESS
of hands at night, differential diagnosis, (replies) [Ehni; Stephens & Welch] 922
NUN
paralysis after injection by; surgeon's responsibility, France, 1163
NURSERY: See Hospitals, nursery
NURSES AND NURSING
chlorpromazine dermatitis in nurses, England, 74
compulsory nursing proposed, United Kingdom, 1532
foreign training centers for native workers, [Gareschè] 503—C
"Guiding Principles and Procedures for Industrial Nurses," A.M.A. publication, 781
program in civil defense planning and requirements, [Whitney] •1195
Today's Health at discount to nurses through Woman's Auxiliary, 295
tuberculosis among nurses, [Myers] 908—ab; (preventing in students) 1183
WHO study of nursing education, 797
NUTRITION
antibiotics relation to, [Grande] 1366—ab
aspects of lipotropic agents in pathogenesis and treatment of fatty liver cirrhosis, (Council article) [Gabuzda] •969
complete nutriment for peptic ulcer, [Winkelstein & Schweiger] •1111
conference in Rome, September, 894
deficient, factor in peripheral nerve lesions during coma, [Olsen] •39
dental caries relation, Italy, 133
endocrine glands and, [Andersen] 322—ab
Institute of Nutrition of Central America and Panama, program, (Council statement) •561
of aged heart patients, [Monat] 708—ab
value of quinua, Peru, 698
NYVARDYE: See Methylphenyl Hydantoin
NYDRAZID: See Isoniazid
NYLON
for seamless arterial grafts, [Sanger & others] •1403
safe around explosive anesthetics? 88
stockings, dermatitis from, United Kingdom, 1256
NYSTATIN
N.N.R., 776
treatment of moniliasis, 159:1803, Dec. 31, 1955, (correction: severe reactions from intravenous method) 160:220, Jan. 21, 1956

O

OBESITY
dislocation (chronic nontraumatic) of second toe in older women, (reply) [DuVries] 728
gangrenous cholecystitis and peritonitis after unrelated surgery fatal in, [Levin] •1040
high blood sugar in obese diabetic woman, 63; high insulin dosage dangerous? 248
juvenile, United Kingdom, 782
treatment, absenoxylum-amphetamine, [McNair] 331—ab
treatment, chorionic gonadotropin in old age, [Simeons] 1365—ab
treatment, 2-phenyl-3-methyl-tetrahydro-1,4-oxazine hydrochloride, United Kingdom 1353
OBITUARIES: See list of Deaths at end of letter D
OBLIVON: See Methylpentynol
OBSTETRICIANS
general-practitioner, England, 413
OCCUPATIONAL Dermatoses: Diseases, Health, etc.; See under Industrial
OCCUPATIONAL THERAPY
for rheumatoid arthritis, [Rae & Bender] •611
workshop in mental hospitals, United Kingdom, 1430
ODOR
deodorizing toilet rooms, 1184
OFFICE: See Physicians
OHIO
Franklin County maternal mortality study, (Council article) •296
State U. transfusion program inaugurated, 685
OIDIUM (Candida) albicans Infection: See Moniliasis
OIL: See also Cod Liver Oil
adjuvants in influenza vaccines, M.R.C. report, England 132; [Stuart-Harris] 321—ab
granulomas, United Kingdom, 701
Iodized: See Iodized Oil
OLD AGE
aged in industry, United Kingdom, 1256
aged in mental hospitals, [Shindell & Cornfield] •1121
agitation in, chlorpromazine for, [Settel] 808—ab; [Terman] 1176—ab
A.M.A. Committee on Geriatrics appointed, 1322
chorionic gonadotropins in geriatrics, [Simeons] 1365—ab

OLD AGE—Continued
dynamic exercises for amputee, [Elsert] 1266—ab
ego disintegration in, [Busse] 242—ab
extremity fractures with gangrene in, [Miller] 598—ab
gangrenous cholecystitis and peritonitis after unrelated surgery fatal in, [Levin] *1040
high blood sugar in obese diabetic woman 63, high insulin dosage dangerous; 248
Hobby show for Older Persons, N. Y., 1337
impotent behavior with reserpine and Ritalin, [Ferguson & Funderburk] *259
medical society requests names of Pennsylvania centenarians, 124
metatarsalic dislocation of second toe in obese women, (reply) [DuVries] 728
nursing home, at Final General Hospital from Hill-Burton funds, Ariz., 61
nutrition of heart patients, [Momat] 708—ab
Pan American Congress on Gerontology, first, Sept. 1958, 229
pelvic findings in women, [Farley] 1266—ab
peptic ulcer complications in, [Stafford] 1433—ab
relief of pruritus with chronic myelogenous leukemia, 520
shock in, blood aminopherase in, [Merrill & others] *1454
sleep behavior in, United Kingdom, 1166
subdural hemorrhage in, [Moore] 913—ab
surgery (abdominal) in, (Swiss society discusses risk) 316; (principles and safeguards) [Gilchrist & Poynter] *1375
surgery for trigeminal neuralgia in, Italy, 133
surgery in, cardiac arrest risk in, [Briggs & others] *1439
too many diagnostic tests? Denmark, 694
vertebral ligamentous calcification in, [Smith] 686—ab
OLIGOPHRENIA: See Mental Defectives
OMENTUM
become strangulated, infarcted and gangrenous in incarcerated hernia? 1538
OMNADIN
treatment plus antibiotics in surgery, [Timmer] 325—ab
OMNAMYCIN
treatment in surgery, [Timmer] 325—ab
OMPHALOCELE: See Umbilicus, hernia
ONYCHOMYCOSIS
treatment, butrioxybenzoic acid ester, Switzerland, 995
OPERATING ROOM: See Surgery
OPERATION: See Surgery; under names of specific organ and disease
Standard Nomenclature: See Terminology
"OPERATION MERCY," civil defense plan of Harris County, Texas, [Olson & others] *1282 [Howard & others] *1211
OPHTHALMOLOGY
Friedenwald Memorial Fund established, 687
sleep therapy in, France, 1438
Survey of Ophthalmology, first issue, February, 1956, 64
ORANGE JUICE
vitamin C standards, (Council report) *1471
ORCHESTRA: See Physicians, avocations
ORCHIECTOMY: See Testes
ORGANS: See also under specific organ
obstruction and perforation of abdominal viscus in children, Brazil, 1252
pathology in schistosomiasis in rats, Brazil, 1427
Society for Artificial Organs, 2nd annual meeting, 1339
vital, experimental hypothermia effects on, [Knocker] 80—ab; [Brancadoro] 334—ab
ORLON
allergy to, desensitize? 1438
for seamless arterial grafts, [Sanger & others] *1403
ORNITHOSIS
from infected birds, 1057—E
increasing incidence, Denmark, 1162
ORTHOPEDICS
role of orthopedic surgeon in cerebral palsy, [Rost & others] *256
OSTEITIS DEFORMANS
of cranium, psychic disturbances in, France, 1163
simulating bone tumors, [Collins & Collins] *431
treatment, cortisone, hydrocortisone, and prednisone? 250
OSTEOARTHRITIS: See Joints, degenerative joint disease
OSTEOCHONDRITIS
simulating bone tumors, [Collins & Collins] *431
OSTEOCHONDROSIS
of capital epiphysis of femur, Thomas splint for, Austria, 784
simulating bone tumors, [Collins & Collins] *431
OSTEOLYSIS
massive, relation to hemangiomatosis, [Gorham] 598—ab
OSTEOMATOSIS
colon polyposis, and soft-tissue tumors with; familial syndrome, [Weiner] 142—ab
OSTEOMYELORETICULOSIS
diagnosis, Switzerland, 797
OSTEOPHYTOSIS
vertebral, clinical syndrome, [Bick] *928
OSTEOSYNTHESIS, history, Brazil, 1427
OTITIS MEDIA
chronic, in children, France, 1349
surgery to preserve hearing in, [Juers] *451
OTOLARYNGOLOGY
international congress (6th), Washington, D. C., 1957, 125
medical, [Davison] *105
OTORHINOLARYNGOLOGY
Congress, Paris, October 1956, 1349
OTOSCLEROSIS
deafness during pregnancy from, 1538
transtympanic stapes mobilized for impaired hearing in, [Kos] 1136—ab
OVARY
cancer, Au^{198} for, Austria, 1046
dysfunction, tetany from, [Sandock] *659
hernia in infants, Austria, 1348
hormones effect on serum histaminedysis, [Spain] 1369—ab
remove in hysterectomy in women under 35? 249
surgery, indications for, [Randall] 810—ab
surgery, oophorectomy for breast cancer, survival after, Brazil, 992
surgery, oophorectomy plus adrenalectomy in breast cancer, [Bastos] 912—ab; [Cuningham] 1174—ab
OVIDUCTS
artificial, pregnancy possible in woman with? 423
hydrotubation with isotonic saline, [Yagi] 328—ab
ligation, indication for cesarean section? 920
OVULATION
rare after last menstruation, contraceptives unnecessary, 152; (advise use for 2 years) [Calderone] 1160
OXAMYCIN: See Cycloserine
OXFORD UNIVERSITY
chemical microbiology chair (Iveagh) established, 228
OXYBUTYLLINE
N.N.R., 467
OXYGEN
deficiency causes cardiac arrest during surgery, [Briggs & others] *1439
deficiency, effect on heart arrhythmia, [Jacoby] 516—ab
restriction to eliminate retrolental fibroplasia, [Guy] 1536—ab
therapy, intra-arterial, (Austria) 694; (and subcutaneous) in peripheral artery disease) [Judmaier] 911—ab
thiopental sodium-nitrous oxide anesthesia, (levallorphan and alphaprodine with) [Foldes & others] *168; (meperidine with) [Ausherman & others] *175
OXYGENATOR PUMP (mechanical heart)
disposable for heart surgery, [Lillehei] 1095—ab
for heart surgery with pulmonary hypertension, [DuShane & others] *950
OXYPHENONIUM BROMIDE
treatment alone or with intermittent positive-pressure breathing in pulmonary emphysema, [Leslie & others] *1125
OXYTETRACYCLINE (Terramycin)
treatment of "home dyspepsia," [Schaper] 329—ab
OXYURIASIS
clothes dryer destroy pinworm eggs? 1538

P

PAS: See *p*-Aminosalicylic Acid
PADISAL
for rest in acute poliomyelitis, [Brehme] 80—ab
PAGET'S Disease: See Osteitis Deformans
PAIN
concomitant in back and abdomen, [Lewin] 1257—C
from breast cancer, spinothalamic section for, [French] 910—ab
in bone in multiple myeloma, treatment, 1374
in joints after splenectomy for purpura, treatment, 1438
of parenteral therapy, injector minimizes, [Figge & Gelhaus] *1308
of terminal cancer, morphine-amiphenazole for, United Kingdom, 1334
over gallbladder after automobile accident, 1185
procaine orally to relieve, 90
simulating sciatica, thoracic and cervical spinal tumors cause, [Scull] *528
PALATE
cleft, and cleft lip, 977—E
PANAMA
Institute of Nutrition of Central America and Panama, program, (Council statement) *561
PANCREAS
alpha cells role in glucagon production, [Korp] 813—ab
annular, in adults, [Dodd] 1179—ab
PANCREAS—Continued
cancer, [Sanders] 1264—ab
cancer of ampulla and head, pancreatoduodenectomy for, [Dennis] 911—ab
fibrocystic disease; generalized disease of exocrine glands, [di Sant'Agnese] *846
fibrocystic disease, probability in children after 1 of 2 has, 1181
fibrocystic disease with bronchopneumonia, Austria, 1348
Islands of Langerhans cell ratio in surgery of hypoglycemia, [Leger] 86—ab
necrosis fatal after choledochotomy and cholangiography, [Hershey] 419—ab
tissue in stomach, hemorrhage with, [Hudock] 910—ab
tumors, adenoma, possible cause of postgastrectomy symptoms [Zollinger & Williams] *367
tumors, B-cell adenoma symptomatology, [Pedrazzini] 908—ab
tumors, hyperinsulinism in, [Breidahl & others] *1196; (surgery and alloxan treatment fail) [Fisher] 334—ab
PANCREATIC DUCTS
bile drainage through, relation to pancreatitis, [Cross] 337—ab; [Doubilet & Mulholland] *521
PANCREATITIS
[Starr] 418—ab
after upper abdominal surgery, [Kern] 911—ab
etiology: prolonged bile drainage through pancreatic ducts, [Cross] 337—ab
in etiology of postcholecystectomy dyskinesia, [Walters] *425
surgical treatment sphincterotomy, [Doubilet & Mulholland] *521
PANCREATODUODENECTOMY
for cancers of ampulla and pancreatic head, [Dennis] 911—ab
PANNICULITIS
relapsing febrile nodular nonsuppurative, [Puget] 804—ab
PANTOPAQUE: See Ethyl Iodophenylundecylate
PANTOTHENIC ACID
to prevent postoperative paralytic ileus, [Orecchia] 1367—ab
PARA-AMINOSALICYLIC ACID: See *p*-Aminosalicylic Acid
PARAFFINOMA
of breast, [Tinckler] 511—ab
PARALDEHYDE
decomposed, danger of, [Agranat] 332—ab
PARALYSIS
after injection by nun, surgeon's responsibility, France, 1162
after penicillin injection, possibly poliomyelitic? 921
agitans, block of globus pallidus in, [Narabayashi] 998—ab; [Copper & others] *1146
agitans, ethopropazine hydrochloride for, [Dushay & others] *346
agitans, quantitative measurement of therapy, [Agate & others] *352
agitans, surgery for, [Cooper & others] *1144
agitans, zoxazolamine for, [Rodriguez-Gomez & others] *752
cerebral, orthopedic surgeon in treatment, [Rost & others] *256
cerebral, psychiatric considerations, [Ahnsjö] 808—ab
cerebral, types, [Herrlin] 808—ab
cerebral, vocational rehabilitation for, N. J., 403
cerebral, zoxazolamine for, [Abrahamsen & Baird] *749
General: See Dementia Paralytica
in postoperative ileus, pantothenic acid to prevent, [Orecchia] 1367—ab
peroneal, after electric shock therapy, [Karliner] 586—C
PARASITES
balantidiasis, Peru, 315
Diphyllobothrium caninum infection in man, 89
from pigeons cause skin rash? 341; (reply) [Burgess] 1186
research in diseases from, Israel, 993
sarcocystis in man, India, 75
Strongyloides stercoralis infestation, specific treatment? 151
PARATYPHOID
from Chinese eggs, England, 227
vaccine dose for children for Asiatic travel, 817
PARENTS
pediatrician examines mother and child, [Kimball] *1033
PARENZYME: See Trypsin
PARESIS: See Dementia paralytica
PARKINSONISM: See Paralysis agitans
PARKINSON'S LAW
growing governmental staffs, United Kingdom, 1089
PAROTID DUCT
calculus in, technic to remove, 1185
PAROTID GLAND
congenital capillary hemangiomas in infancy, [Campbell] 999—ab
fat infiltration simulating tumor, [Gilman & others] *18

PAROTITIS
sequel, auriculotemporal syndrome, [Gardner & McCubbin] *272
PARSIDOL: See Ethonropazine Hydrochloride
PASKALIUM; PASKATE: See Aminosalicylate, Potassium
PATCH Tests: See Skin tests
PATHILON IODIDE: See Tridihexethyl Iodide
PATHOLOGY
geographic, international congress, Paris, 1957, 125
practice by Iowa hospitals illegal, 53—E; [Medicine and the Law] 58
Society of Pathological Anatomy founded, Peru, 698
tissue committee in hospital accreditation, [Medicine and the Law] *1238
value of autopsy, guest editorial by Dr. Starr, 1144—E
PATIENTS: See also "Abandonment of Patient" under Medicolegal Abstracts at end of Letter M
press discusses complaints of, Sweden, 886
PEDIATRICS
Pediatric Society of Central New Jersey formed, 1078
pediatrician examines mother and child, [Kimball] *1033
social, course at International Children's Centre, Paris, 883
PELLEGRINI-STIEDA DISEASE
treatment, 727
PELVIS
findings in women past 65, [Farley] 1266—ab
roentgen study using a single film, [Thoms & Billings] *1148
tuberculosis, treatment, 152; (replies; advise long-term therapy) [Donnelef; Ross] 1269
PEMPHIGUS
treatment, cortisone and ACTH, [Nelson] 244—ab
vulgaris, long-term ACTH for, [Stoughton] *1011
PENTOMID
treatment of eclampsia, [Cossutta] 82—ab
PENICILLIN
bacterial resistance, serial subculture in mixtures effects, [Molomut & others] *967
Benzathine G: See Benzathine Penicillin G
economics of prescribing various types, England, 314
G and V orally, blood levels from; relation to food intake, [Jones] 85—ab
injection, paralysis after, 921
Phenoxymethyl: See Penicillin V
Pimpri, put on market, India, 797
procaine, in gonorrhea, Sweden, 896
streptomycin simultaneously, blood levels after, [Hassing] 509—ab
to prevent polyhydramnios during 2nd pregnancy? 921
to prevent rheumatic fever, throat bacteria in, [Miller] 1261—ab
toxicity, allergy; ACTH and cortisone in, [Fitzgerald] 883—ab
toxicity, allergy, fatal and nonfatal, [Peters] 1178—ab
toxicity, allergy, guest editorial, by Drs. S. M. and A. R. Feinberg, 778—E
toxicity, deaths from, Denmark, 412; (reply; problem of telling layman) [Troan] 1258—C
toxicity; serum sickness, prednisone for, [Feinberg & Feinberg] *264
treatment of carbuncle, 340; (correction) 985
treatment of leptospirosis fails, United Kingdom, 1089
treatment of neurosyphilis, United Kingdom, 1254
treatment of peritonitis after acute appendicitis, 921
treatment of subacute bacterial endocarditis, [Mendelson & others] *137; [Henriksen] 882—ab
treatment of winter recurrent sore throat with fever, 151
V, [Martin]; (oral, blood levels; relation to food intake) [Jones] 85—ab; (Switzerland) 1531
V, clinical use, [Martin & others] *928
V for subacute bacterial endocarditis, [Quinn & others] *931
PENIS
cancer in man circumcised in infancy, [Paquin] 330—ab
indurated corpora cavernosa, possibly tumor metastases, (reply) [Paquin & Roland] 610
Peyronie's disease, hydrocortisone for, [Zacharias] 423—ab
PENSIONS: See Retirement
PENTAPYRROLIDIN BITARTRATE: See Pentolinium Tartrate
PENTAPYRROLIDIUM: See Pentolinium Tartrate
PENTOBARBITAL SODIUM
treatment of postanesthetic nausea, vomiting, and retching, [Knapp & Beecher] *376
PENTOLINIUM TARTRATE
treatment of severe hypertension, [Bauer] 418—ab
PENTOTHAL: See Thiopental
PEPSINOGEN
in urine should be routine test, Peru, 315
PEPTIC ULCER
acute perforated, subtotal gastric resection for, [Bisgard] *363
alcoholism and gastric type, [Navratil] 138—ab
bleeding, diagnosis and management, [Berkowitz & others] *1398
bleeding duodenal ulcer, suture control, [Albright] 326—ab
bleeding, prognosis, insurance mortality study, [Bolt & Lew] *736
bleeding, 250 cases, [Manning] 507—ab
complications in old age, [Stafford] 1433—ab
coronary disease relation, British society discusses, 313
diet for, [Doll] 904—ab; (normal vs. special, United Kingdom) 1089
diets increase chance of coronary arteriosclerosis? 424
etiology, lysozyme in, Austria, 1251
etiology, prednisone and prednisolone, [Boland] *613; (reply) [Brick] 1168—C
International Society of Geographic Pathology to meet, 1025
milk drip for gastric type, United Kingdom, 1255; [Doll] 1365—ab
of esophagus, [Wolf] 706—ab
review of 9,300 autopsies, Sweden, 698
surgical treatment, gastrectomy (subtotal), follow-up, [Metcalf] 595—ab; (multiple deficiencies after) [Morin] 1264—ab
surgical treatment of duodenal type, (managing cases after) [Chester] 241—ab; (considerations in) [Zollinger & Williams] *967
treatment, complete nutriment for, [Winkelstein & Schweiger] *1111
PER-ABDOMIL
kidney excretion of, Austria, 1087
PERICARDITIS
chronic constrictive, surgical indications, [Dubost] 324—ab
post-myocardial-infarction syndrome resembling, [Dressler] *1379
tuberculous, antibiotics and corticosteroids for, France, 1162
PERICARDIUM
de-epicardialization for angina pectoris, [Harken] 1095—ab
PERINEUM
surgery, abdominoperineal proctosigmoidectomy with sphincter preservation, [Bacon] *828
surgery, complete perinectomy, [Cunningham] 328—ab
PERIODICALS: See Journals
PERIODONTAL DISEASE
significance of bleeding gums, 1056—E
PERITONEUM
endometriosis, [Ramse] 715—ab
foreign bodies, bean in cavity after vaginal insertion, United Kingdom, 1353
Irrigation: See Kidneys, artificial
retroperitoneal tumors, Italy, 696
PERITONITIS
after appendicitis, choice of antibiotic for, 921
gangrenous cholecystitis with, after unrelated surgery fatal, [Levin] *1040
PERMAPEN: See Benzathine Penicillin G
PERSPEX: See Polymethyl Methacrylate
PERUVIAN MEDICAL ASS'N. vs. Social Welfare on medical service plans, 1164
PETHIDINE: See Meperidine
PETROLEUM PRODUCTS: See also Kerosene; Solvents
in etiology of occupational dermatoses, [Klauder] *442
PEUTZ-JEGHERS SYNDROME
polyps and pigment in, [Freeman] 327—ab
PEYRONIE'S Disease: See Penis
PFEIFER-WEBER-CHRISTIAN Disease: See Panniculitis
PHARMACEUTICALS: See Drugs
PHARMACISTS
chlorpromazine dermatitis in, England, 74
PHARYNGITIS
acute, cervical vertebra dislocation after, Austria, 794
streptococcic, prevent rheumatic fever by treating, [Morris & others] *114
PHARYNX
pharyngeal pouch, surgery for, [Howden] 139—ab
PHELANTIN
treatment of epilepsy, [Davidson & Berman] *766
PHENERGAN: See Promethazine
PHENOBARBITAL
chlorpromazine-amobarbital with, for sleep in ophthalmology, France, 1428
treatment plus Dilantin and methamphetamine in epilepsy, [Davidson & Berman] *766
PHENOTHIAZINE
derivatives for acute poliomyelitis, [Brehme] 80—ab
derivatives for multiple sclerosis, [Seyffert] 998—ab
PHENSUXIMIDE
N.N.R., 1405
PHENYLALANINE
free hydrolist for phenylpyruvic oligophrenia? 88; (reply) [Glaser] 922
PHENYLBUTAZONE
treatment, [Denke] 708—ab
treatment of superficial thrombophlebitis, [Stein] 85—ab
2-PHENYL-3-METHYLTETRAHYDRO-1: 4-OXAZINE HYDROCHLORIDE
weight reducer, United Kingdom, 1353
3-(1-PHENYLPROPYL)-4-HYDROXYCOUMARIN
anticoagulant studies, [Prior] 84—ab
PHENYTOIN: See Diphenylhydantoin Sodium
PHEOCHROMOCYTOMA
diagnosis, [Orgain] 593—ab
PHILATELY: See Postage Stamps
PHLEBITIS
edema control with constrictive dressings, [Olwin] *1101
prognosis insurance mortality study, [Bolt & Lew] *736
PHLEBOGRAPHY: See Veins, roentgen study
PHLEBOLITHS: See Veins, calculi
PHOLCODINE
treatment of cough, United Kingdom, 1429
PHOSPHATASE
blood acid, elevated in prostate cancer, [Hudson] 811—ab
PHOSPHATE, SODIUM RADIO-(P^{32})
N.N.R., 689
PHOSPHORUS
radioactive, for capillary nevi, [Roe] 421—ab
radioactive, for lymphocytic leukemia and Hodgkin's disease, Austria, 1866
radioactive, to study urinary excretion, Austria, 1086
PHOTOGRAPHY
explosion hazard of strobelights in operating rooms? *16
medical, [Leisure Corner] *416
motion picture, [Leisure Corner] *1259
of uterine canal tumors with water hysteroscope and endoscopic camera, [Norment & Sikes] *1014
PHYSICAL EXAMINATION
doctors' opinions on cancer program, (Miscellany) *1171
for students, U. of Illinois alters, 1241
for the handicapped, urges practitioners to evaluate, [Maas] 1090—C
yearly, value in women, [Rutherford & Banks] *1289
PHYSICAL MEDICINE
aid for blind physiotherapists in giving ultraviolet light, United Kingdom, 898
biophysical basis, [Schwan] *1191
for low back pain, [Diveley & others] *729
for poliomyelitis sequelae, Belgium, 795
for rheumatoid arthritis, [Rae & Bender] *611
importance of diagnostic methods, especially electric current, [Licht] 76—C
PHYSICIANS
A.M.A. advisory committee for television, radio, and motion pictures, 1147; 1322
A.M.A. public opinion survey, 1170—E; 471
anonymity on the air, British Medical Ass'n. examines, 1531
attorneys and, mutual understanding, [Medicine and the Law] *1411
avocations, American Medical Golfing Ass'n. annual tournament, 1526
avocations, autobiographies, [Leisure Corner] *77
avocations, chorus, N. J., 881
avocations, composer of symphonic suite: Dr. V. T. Williams, 784
avocations, orchestras, (Brooklyn) 217; (New York) 570
avocations, philately; recent stamps, 218
avocations, photography, [Leisure Corner] (medical) *416; (motion picture) *1259
avocations, Physicians Art Ass'n. exhibit at A.M.A. Meeting, 1088
avocations, spring gardening, [Leisure Corner] *1092
career opportunities in government, 1342
careers, time after graduation relation to specialization, [Terris & Monk] *653
civilians, and future security; military service problems, (reply) [Hahn & Raffensperger] 899—C
College of Physicians and Surgeons of South Africa established, 228
Connecticut, distribute family health record, [Public Relations] *60
Deaths: See list of Deaths at end of letter D
disability after removing acoustic neuroma in, rehabilitation? 340
encourages contributions to American Medical Education Foundation, President Hess' Page, 1146
filling gap between academic and practical medicine, [Stone] *1208
foreign, enrolled at Air Force School of Aviation Medicine, 691
foreign, report of cooperating committee on, 978
German, stand on Adenauer health insurance plans, 228
heart, progress, and vision in 20th century, [McDaniel] *1193

PHYSICIANS—Continued
hospital relationships, A.M.A.-A.H.A. Liaison Committee to be continued, 1322
illnesses treated by, (Bureau article) [Dickinson] *213
in NHS, alleged refusal to treat patient, England, 153
Income Tax: See Tax
Industry needs, 1411—E
investments, municipal bonds, (Business Practice) [Burgett] *136; (reply) [Walker & Robinson] 880—C
Investments while visiting Europe, (Business Practice) [Mitchell] *74
lieutenants promoted to captains, (Air Force) 376; (Army) 691
medical school alumni, (Bureau article) [Dickinson] *473
military liability, 495; (A.M.A. information on) 1413
newspaper coverage of information on, [Wilmer] *663; *768; (replies) [McDowell; Wren] 1236; [Ford] 1237; (reply) [Wilmer] 1247
office establishment, [Business Practice] *233; *319; *504; *569; *900; *1356
office, multipurpose clip from ready-made box tiles, [Hyman] 76—C
office mycology procedures, [Robinson & others] *537
opinions on cancer program, (Miscellany) *1171
opinions on voluntary health insurance, A.M.A. survey, 400—E
patient complaints against, press discusses, Sweden, 896
placement, state programs, (Council article) *1414
practicing, as faculty members, problems, 979
practicing, economics of prescribing samples in rural areas, United Kingdom, 1167
practicing, general practitioner appointments in Northern Ireland hospitals, 412
practicing, general practitioner, importance; relation to specialists, [Friery] 1257—C
practicing, general practitioner in cancer detection, [Boles & others] *923
practicing, general practitioner in evaluating physical handicap for industry, [Maas] 1090—C
practicing, general practioner obstetricians, England, 413
practicing, general practitioner, report of College of, United Kingdom, 896
Presidential, pictorial exhibit, D. C., 215
public health department and, [Pinckney] *1450
relation to newspapers, radio, and television, [Problem Corner] *60
Russian, visit Great Britain, 74
Social Security for: See Social Security
supply, Fellowship for Freedom in Medicine discusses, England, 226
supply, world census, Switzerland, 995
telephone answering services, [Public Relations] 1416
voluntary health agencies and, [Public Relations] *60
women, allen: New England Hospital plan for, guest editorial by Dr. Bearse, 562—E
younger, encouraged to take part in local medical societies, (President's Page) 283
PIGEONS
shed parasites or products that cause skin rash? 341; (reply) [Burgess] 1186
PIGMENTATION
in Peutz-Jeghers syndrome, [Freeman] 327—ab
PIGS: See Hogs
PIMPRI PENICILLIN put on market, India, 797
PINWORM INFECTION: See Oxyuriasis
PIPERAT Tartrate: See Piperazine tartrate
PIPERAZINE
citrate, tests and standards, 1052
hexahydrate, tests and standards, 1053
hydrate for ascariasis, Brazil, 1161
tartrate, tests and standards, 1052
PIPERIDYLAMIDONE
treatment of cough, United Kingdom, 1429
PIPRADROL HYDROCHLORIDE
N.N.R., 390
PITRESSIN: See Vasopressin
PITUITARY
effect on menopausal vasomotor instability, [Heilbaum] 999—ab
Pitressin in water metabolism, Israel, 581
Sheehan's syndrome, [Taylor] 899—ab
stalk function, [Harris] 337—ab
PIUS XII (Eugenio Pacelli): pope
names Dr. S. W. Georges, Knight of Order of St. Gregory the Great, 686
PLACEBO
to evaluate analgesics, (replies) [Salamon] 703—C; [Margolis] 880—C
to evaluate antiemetics, [Knapp & Beecher] *376
to evaluate chlorpromazine and reserpine in emotional disorders, [Zeller & others] *179
PLACEBO—Continued
to evaluate drugs, statistical studies, (reply) [Best] 586—C
to evaluate drugs to prevent motion sickness aboard transport ships, *755; (correction) 1061
to evaluate edrophonium chloride test for myasthenia gravis, [Osserman & Teng] *153
to evaluate Rauwolfia effects on nervous and cardiovascular systems, [Lewis & others] *822
variable in evaluating hypotensive drugs, [Shapiro] *30
PLACEMENT: See Physicians
PLACENTA
abruptio with granulosa cell cancer, [Barrett] 1265—ab
retained, 313 cases, India, 894
PLAGUE
vaccination for children for Asiatic travel, 817
PLANIGRAPHY: See Roentgen Rays
PLANING
of skin for defects, [Grais] 603—ab
PLASMA: See also under various subheads of Blood
expanders, increased use, United Kingdom, 700
plasmacytopenia in thymus tumor, (Diagnostic Problems) [Ramos] *1317; (comment) [Loeb] *1319
PLASTICS
allergy to, desensitize? 1438
for patios, sunburn through? 1438
PLEURA
endometriosis, incidence, 1185
tumors, lymphoma, [van Hazel] 912—ab
PLEURISY
tuberculous, in Finnish Armed Forces, 892
tuberculous serofibrinous, hormones for, France, 1162
tuberculous, with effusion, prednisone for, [Baroni] 1534—ab
with effusion, in Algeria, France, 1350
PLOMBAGE
extraperiosteal apicolysis with, United Kingdom, 1532
PLUNKETT, RICHARD J., associate director of Joint Commission on Mental Illness and Health, 879
PLUTONIUM
mobilization, nephrosis from edathamil calcium-disodium for, [Foreman & others] *1042
PNEUMATIC CUFF
for temporary arterial occlusion, [Gardner & Salmoiraghi] *1224
PNEUMONECTOMY: See Lungs surgery
PNEUMONIA
caseous, cicatrical cavities after treatment, Switzerland, 1428
cortisone and ACTH fatally suppress symptoms, [Page] 239—ab
incidence, United Kingdom, 799
interstitial pneumonitis in dermatomycosis, [Mills & Mathews] *1467
staphylococcal, [Brownrigg] 328—ab; (in infants) [Wellman] 716—ab
PNEUMONITIS: See Pneumonia
PNEUMONOCONIOSIS
byssinosis and cadmium poisoning, United Kingdom, 1167
cyanosis and dyspnea in silicosis, [Tronchetti] 86—ab
emphysema relation to dust exposure, (reply to Dr. Sander) [Mayer & others] 230—C
silicosis, 4 stages of development, Italy, 1164
PNEUMOPERITONEUM, ARTIFICIAL
for tuberculosis? 342
for tuberculosis: spontaneous pneumothorax after, Brazil, 312
to determine esophageal hiatus hernia relation to angina pectoris, [Maisel & Horger] *868
x-ray hazard after, United Kingdom, 585
PNEUMOTHORAX
spontaneous, after pneumoperitoneum for tuberculosis, Brazil, 312
spontaneous, lung resection for, [Ehrenhaft] 326—ab
PNEUMOTHORAX, ARTIFICIAL
aortic puncture from trying to refill, United Kingdom, 1256
x-ray danger after, United Kingdom, 585
POISONING
amphetamine, United Kingdom, 1430
barbiturate, (Denmark) 694; 1162; (United Kingdom) 1351
carbon monoxide, (United Kingdom) 702; (Switzerland) 1531
chlorine, in public baths, United Kingdom, 701
Food: See Food poisoning
in Children: See Children
Industrial: See Industrial Dermatoses: Industrial Diseases
methanol, in sailors, Canada, 1088
morphine, Denmark, 1162
mustard gas in veterans, bronchitis relation to cancer after, England, 314
POLIOMYELITIS
acute, cardiovascular collapse in, [Hilden] 1173—ab
POLIOMYELITIS—Continued
acute phase, rest with drugs, especially phenothiazine, [Brehme] 80—ab
acute; relaxotherapy, hyperproteinization and supportive therapy, (scientific exhibit) [Boines] [1] Jan. 28
artificial respiration via uncuffed tracheostomy tube in, [Mörch & others] *864
contacts, serologic studies, [Berger] 1368—ab
hyaluronidase and renal calculi in, [Taylor] 330—ab
immunity after smallpox vaccination, United Kingdom, 1167
immunity conferred to infant, 152
immunity in Welsh village, 1255
in community of high socioeconomic level, [Nolan] 512—ab
in Italy, 228
in pregnancy, incidence, 520
in pregnancy, incidence in relation to age, parity and gestation, [Weinstein] 144—ab; [Siegel] 513—ab
increase, (United Kingdom) 1351; (paralytic type) 1423
National Foundation for Infantile Paralysis: See Foundations
paralysis after penicillin injection from? Avoid injections during epidemic? 921
pregnancy advised after attack with abdominal transplant and weak back? 1268
sequelae, physical medicine for, Belgium, 795
spread in nursery schools, [McCarroll] 600—ab
subclinical, in infant from intrauterine infection, [Shelokov & Habel] *165
susceptibility to? 1004
treatment and Salk vaccine, Russian scientists study, 404
vaccination, Denmark, 694
vaccination in Massachusetts evaluated, [Pope] 1265—ab
vaccination program, *Brit. M. J.* criticizes Ministry of Health on, 996
vaccine, booster shots effect on serologic status, [Brown] 600—ab
vaccine (Salk), A.M.A. Committee on, 1333
vaccine (Salk), early and later vaccines, [Ratner] 231—C
vaccine (Salk) emergency schedule, [Van Riper] 1251—C
vaccine (Salk-type) developed, United Kingdom, 1254
vaccine, USPHS releases, 989
virus (attenuated strains) for oral immunization, [Koprowski & others] *954; (British research on) 1167
virus in regional lymph nodes, [Wenner] 600—ab
WHO report on fight against, 315
POLLENS
air filter for asthma from? 921
POLYNATE
tests and standards, 1055
POLYARTHRITIS: See Arthritis, Rheumatoid
POLYCYTHEMIA
vera, neurologic symptoms, Brazil, 313; 1427
POLYETHYLENE SPONGE
packs and Perspex for extraperiosteal apicolysis with plombage, United Kingdom, 1532
POLYHYDRAMNIOS
penicillin to prevent in 2nd pregnancy? 921
POLYMETHYL METHACRYLATE
Polystan with, for extraperiosteal apicolysis with plombage, United Kingdom, 1532
POLYPS
in Peutz-Jeghers syndrome, [Freeman] 327—ab
nasal, deep therapy and/or irradiation to prevent recurrence? 250
of colon with osteomatosis and soft-tissue tumors: familial syndrome, [Weiner] 142—ab
POLYSTAN: See Polyethylene Sponge
PONTOCAINE: See Tetracaine
PORPHYRIA
complicating pregnancy, medication in etiology, [Durst & Krenbs] *165
toxic, hibernation for, [Muller] 1365—ab
PORTAL VEIN
hypertension, managing during shunt surgery, [Rheiling] 1175—ab
obstruction in children, diagnosis, [Schuckmell] 602—ab
obstruction, shunt for, [Kaufmann] 910—ab
shunt into systemic system for bleeding esophageal varices, [Linton & Ellis] *1017
POSTAGE STAMPS
recent issues for physician philatelists, 218
POSTOPERATIVE: See Surgery
POSTURE
dyspnea from lying on left side, 1374
POTASSIUM
Aminosalicylate: See Aminosalicylate
chloride for aldosteronism in pregnancy, N. Z., 229
chloride for cirrhosis, Peru, 134
chloride for ventricular defibrillation, [Bornmeister] 709—ab
effect on colon contractions, France, 992

POTASSIUM—Continued
hydroxide and ink staining, for mycological diagnosis, [Robinson & others] *537
hyperkalemia and aldosteronuria, Switzerland, 1165
losing nephritis, aldosteronism, [Conn] 904—ab
surcharge and carboanhydrase inhibitor, Switzerland, 1429

POTATOES
"moth-ball," from insecticides, England, 74

PRACTICE of Medicine: See Medicine, practice; Physicians, practicing

PRANTAL Methylsulfate: See Diphemanil Methylsulfate

PRECIPITIN
test in coccidioidomycosis, [Smith & others] *546

PRECIPITRON
air filtering with, for pollen asthma? 921

PREDNISOLONE (Metacortandralone)
treatment of lymphocytic leukemia, lymphoma, and Schönlein-Henoch purpura, England, 226
treatment of rheumatoid arthritis [Hart] 239—ab; [Boland] *613; (reply: question of peptic ulcer etiology) [Brick] 1168—C
treatment of skin diseases, [Frank] 245—ab
treatment of tuberculous arthritis, United Kingdom, 799

PREDNISONE (Metacortandracin)
clinical survey, [Küchmeister] 138—ab
effects, clinical and metabolic, [Nabarro] 239—ab
effects on skin homotransplants, N. Z., 229
symposium on, Switzerland, 414
toxicity simulating cerebrovascular accident, [Schroeder & Sherman] 1354—C
treatment of acquired hemolytic anemia, [Sussman & Dordick] *285
treatment of allergies, [Feinberg & Feinberg] *264
treatment of asthma, [Capuani] 85—ab
treatment of cirrhosis, France, 1427
treatment of diffuse scleroderma, [Rodnan] 905—ab
treatment of heart insufficiency, Switzerland, 994; (correction) 1341
treatment of lung edema and fibrosis, Switzerland, 994; (correction) 1341
treatment of lymphocytic leukemia, lymphoma and Schönlein-Henoch purpura, England, 226
treatment of osteitis deformans? 250
treatment of polyarthritis, Switzerland, 229
treatment of post-myocardial-syndrome, [Dressler] *1379
treatment of retinitis with macular edema, [Gordon] 610
treatment of rheumatoid arthritis, [Hart] 239—ab; [Cohen] 709—ab
treatment of rheumatoid arthritis, [Boland] *613; (reply: role in peptic ulcer etiology), [Brick] 1168—C
treatment of tuberculous arthritis, United Kingdom, 799
treatment of tuberculous pleurisy with effusion, [Baroni] 1534—ab

PREECLAMPSIA: See Eclampsia

PREGNANCY
advised after poliomyelitis with abdominal transplant and weak back muscles? 1268
androgens during, fetal hermaphrodism after, [Hoffmann] 1535—ab
artificial fallopian tubes allow? 423
aspermia during coitus, can man be helped? 249
Christian Science vs. hypnotism in, (reply) [Davis] 76—C
complications: aldosteronism, potassium chloride for, N. Z., 229
complications: anemia, Ireland, 797
complications: deafness, diagnosis, 1538
complications: diabetes, female hormones for, [White] 715—ab
complications: extragenital cancer, [Hebold] 999—ab
complications: granulosa cell cancer with abruptio placenta, hemoperitoneum and intestinal obstruction, [Barrett] 1265—ab
complications: poliomyelitis incidence, 520
complications: poliomyelitis incidence relation to age, parity and gestation, [Weinstein] 144—ab; [Siegel] 513—ab
complications: poliomyelitis, subclinical infection in infant from, [Shelokov & Habel] *465
complications: porphyria, medication in etiology, [Durst & Krembs] *165
complications: thrombophlebitis, France, 1350
complications: varicose veins, hormonal cause, [Fried] 1535—ab
ectopic, abdominal; diagnosis after 2 years, India, 893
ectopic, etiology: new concept, [Asherman] 513—ab
estimating uterine blood flow at term, [Metcalfe] 81—ab

PREGNANCY—Continued
gestation and cervix cancer [Runge] 82—ab
heart surgery during, Switzerland, 1350
in infertile couples, [Keettel & others] *102
isoniazid effect on, [Abouliker] 1535—ab
not advised after pelvic tuberculosis, 152
ovarian hormones effect on serum histaminolysis, [Quaini] 1369—ab
pelvimetry using single x-ray film, [Thoms & Billings] *448
radioactive sodium chloride to study blood flow in, Austria, 1086
rupture of uterus during, [Bak] 144—ab
second, prevent polyhydramnios with penicillin? 921
toxemia and hypertension, Rauwolfia for; effect on infant, [Finnerty] 997—C; [Rogers] 1090—C
toxemia, 1,4-dihydrazinophthalazine and reserpine for, [Balassi] 82—ab
toxemia (eclamptogenic), conquest of, [Falls] *251
toxemia, veratrum and Rauwolfia for, [Voskian] 999—ab
vaginal smear to determine date of delivery, [Lemberg-Siegfried] 82—ab
vomiting, ACTH for, [Järvinen] 420—ab; 580
vomiting and nausea in, status of therapy, (Council report) *208; (bonamine in) [Lebherz] 420—ab

PREOPERATIVE: See Surgery

PRESCRIPTIONS
economic problems in rural communities, United Kingdom, 1167
economic problems, what is a drug? United Kingdom, 1167
out-of-state doctor writing legal? 610
regional variations in cost, United Kingdom, 1256

PRESERVATIVES
for food, chlortetracycline; FDA approved, 779—E

PRESS
A.M.A. liaison, [Public Relations] *59
discourage publicity on penicillin deaths, Denmark, 412; (reply: layman should know) [Troan] 1258—C
facts and feelings about medical coverage in, [Wilmer] *663; *768; (replies) [McDowell; Wren] 1236; [Ford] 1237; (reply) [Wilmer] 1237
hospitals agree on release of patient information, England, 72
libelous article on Royal College of Obstetricians and Gynecologists, 1256
physician and medical societies relation to, [PRoblem Corner] *60

PRESSURE
sound for pyloric stenosis, Austria, 1348

PRESTO INJECTOR
minimizes pain of parenteral therapy, [Figge & Gelhaus] *1308

PRIAPISM
from antihistamines for hay fever? 1184

PRIZES
AAAS-Anne Frankle Rosenthal Memorial Award for cancer research, 784
American College of Chest Physicians, for manuscript on pulmonary edema, 64
American College of Gastroenterology, Ames contest in gastroenterology, 61
American College of Radiology Gold Medal, 1339
American Dermatological Ass'n. essay contest, 304
A.M.A. Distinguished Service Award, request nominations, 1410—E
A.M.A. to present science fair awards, 781
American Society of Maxillofacial Surgeons, essay contest, 405
Anderson (F. Paul) Medal of American Society of Heating and Air Conditioning Engineers, 216
Anderson-Berry (David) Medal for x-ray studies, England, 687
Andrew (John A.) Clinical Society, distinguished service award, 1241
Ashford (Bailey K.), nominations open, 1339
Ass'n. of Medical Writers and Artists gold medal to Dr. Blanco Soler, Spain, 896
Barton (Alberto) Award for bartonellosis research, Peru, 134
Blakeslee (Howard W.), 1339
Bronx County Medical Society essay contest for high school graduates, 1419
Buffalo Surgical Society Gold Medal, 784
Criss (C. C.) Award nominations accepted, 491
Distinguished Service Award in Jeanerette, La., 1419
Friedenwald (Julius) Medal, 1525
Jeffries (John) Award, 495
Kimble Methodology Research Award, nominations requested, 1151
Lahey (Frank H.) Memorial Award, 1322
Landsteiner (Karl), in blood banking, 63
Lederle Medical Faculty Award, 1079
Lennox (William G.) Citation in epilepsy, 571
Louisiana College Distinguished Service Award, 302

PRIZES—Continued
Mississippi Valley Medical Society, essay contest, 65
National Nephrosis Foundation, Thomas Addis Medal, 215
National Safety Council President's Medal, 1342
New York Academy of Medicine's Plaque and Medal, 303
Nobel Prize in physiology and medicine to N. H. Theorell, Sweden, 134
Norfolk's First Citizen in Civic Affairs Medal to Dr. W. B. Martin, Va., 686
Northern Tri-State Medical Ass'n., Distinguished Medical Citizenship, 1245
Order of Merit of Carlos J. Finlay, 124
Order of the Sons of Italy in America, to first woman, 218
Phi Delta Epsilon Distinguished Service Award, 126
Phi Lambda Kappa Gold Medal for American doctor of Jewish origin, 783
Phillips Medal, 159:1554, Dec. 17, 1955; (correction) 160:66, Jan. 7, 1956
President's Committee on Employment of Physically Handicapped Award to Dr. Rowntree, (photo) 677; 783
St. Louis College of Pharmacy and Allied Sciences Alumni Award for service to medicine, 302
Sedgwick Medal awarded posthumously to Dr. Chesley, 404
Seibert Memorial, 404
Silver Beaver Award, 1338
Strittmatter (Isidor T.) Award, 571
U. of Minnesota Outstanding Achievement Award, 218
Van Meter Prize Essay, 1525

PROCAINE AMIDE HYDROCHLORIDE
treatment of pruritus in man 64 with chronic myelogenous leukemia, 520
treatment of ventricular fibrillation, [Burmeister] 709—ab

PROCAINE HYDROCHLORIDE
to block globus pallidus in paralysis agitans, [Narabayashi] 998—ab; [Cooper & others] *1444
to relieve pain, 90
treatment, intra-arterial, in arteritis, France, 1163
treatment of toxicosis in nurslings, [Giusti] 1000—ab
treatment of ventricular fibrillation, [Burmeister] 709—ab

PROCTOSIGMOIDECTOMY
abdominoperineal, with sphincter preservation for rectal cancer, [Bacon] *628

"PROFESSOREN COLLEGIUM" of U. of Vienna, oil painting given to International College of Surgeons, (photo) 405

PROGESTERONE
treatment of amenorrhea, Israel, 994
treatment of pregnant diabetics, [White] 715—ab
treatment of premenstrual eczema, 341; (reply) [Greenblatt] 1186

PROGNATHISM
surgery for, in infants, Italy, 133

PROMETHAZINE
to prevent motion sickness aboard transport ships, *755; (correction) 1081

PRONESTYL: See Procaine Amide Hydrochloride

PROSTATE
cancer, antiandrogenic therapy, [Ganem] 916—ab
cancer, blood acid phosphatase and liver dysfunction in, [Hudson] 811—ab
cancer, prognosis, [Fabry] 917—ab
cancer, transurethral resection for, [Pool & Thompson] *833
cancer with hemorrhagic diathesis, [Prout & others] *840
palpable nodule significance, [Jewett] *838

PROSTATECTOMY
Italian urologists discuss technics, 894
transurethral, and hemolysis, [Creevy] 916—ab
transurethral, dilutional hyponatremic shock during, [Harrison] 1436—ab
transurethral, for cancer, [Pool & Thompson] *833

PROSTATITIS
chronic—fact or fiction? [O'Shaughnessy & others] *540; (replies) [Moore; Rosenbloom] 1257—C

PROSTHESIS
exoskeletal splithook, for traumatic tetraplegia in arms, [Nyquist] *761
rehabilitation course at New York U., 685
woven synthetic, in vascular system, [Deterling] 807—ab

PROTEIN
deficiency, treatment, [Occhipinti] 805—ab
high diet for acute poliomyelitis, (scientific exhibit) [Boines] [1] Jan. 28
low diet, for diabetic kidney complications, [Allen] 135—C
malnutrition, liver enzymes in, India, 796

PROTEIN—Continued
nutrition in alcoholic cirrhosis, (Council report) [Davidson] *296
fractions, radioiodinated albumin to study, Austria, 1060
research, Rockefeller Foundation grants, England, 237
PROTEINURIA: See Albuminuria
PROTHROMBIN: See Blood prothrombin
PROTOVERATRINE
treatment of hypertension, variables in evaluation, [Shapiro] *30
PROTOVERATRINE A AND B MALEATES
tests and standards, 1053
treatment of hypertension, [Guzzi] 719—ab
PROTOVERATRYL: Provell: See Protoveratrine A and B Maleates
PRURITUS
relief in man 64 with chronic myelogenous leukemia, 520
PSEUDARTHROSIS
treatment, Phemister's subperiosteal onlay or intracortical bone grafts, [Ritter] 142—ab
PSITTACOSIS: See Ornithosis
PSORIASIS
after injection against patient's will, boy awarded damages, England, 314
complications: arthritis, United Kingdom, 799
skin grafts in, 1003
PSYCHIATRY
Eastern Psychiatric Research Ass'n. founded, 788
for fear of needles in otherwise normal woman, 1100
pediatric, summer course at U. of Vienna, 305
PSYCHOANALYSIS
factors favoring curative effect, [Menz] 143—ab
PSYCHOLOGY
factors in delay in seeking surgical care, [Pitchener & others] *1187
PSYCHONEUROSES
in etiology of porphyria, [Durst & Krenbs] *1065
PSYCHOSIS
alcoholic, hepatotherapy, France, 694
in cystitis deformans of cranium, France, 1163
manic-depressive, chlorpromazine and reserpine for, [Zeller & others] *1179
methylpentynol causes, England, 159; 1232, Nov. 19, 1955; (correction) 160: 787, March 3, 1956
treatment chlorpromazine and reserpine compared, [Kovitz] 143—ab
treatment: chlorpromazine, reserpine, inopazid, [Hewat] 143—ab
PSYCHOSOMATIC DISEASE
gastrointestinal, chlorpromazine for, [Asher] *1284
in otolaryngology, [Davison] *1067
neurovegetative dystonia, Switzerland, 994
psychosexual, in chronic prostatitis without inflammatory processes, (reprints) [Moore; Rosenbloom] 1257—ab
treatment: Rauwolfia, [Lewis & others] *622
PTOSIS: See Eyelids
PUBERTY: See Adolescence
PUBLIC HEALTH: See Health, public
PUBLIC OPINION
about physicians, A.M.A. survey, 59; 470—E; 471
PUBLIC RELATIONS
A.M.A. plans: family health record; physician and health agencies, *59; *60
county secretaries seminar, Michigan sponsors, 216
San Mateo County study of newspaper medical coverage [Wilmer] *663; *768; (replies) [McDowell; Wren] 1236; [Ford] 1237; (reply) [Wilmer] 1237
snowballing social security, *485
telephone answering services, 1416
PUERPERIUM
complications: mastitis, (x-ray for) [Rossi] 514—ab; (microcoecic, effect on infant) [Ferrario] 1369—ab; [Gunther] 1434—ab
complications: mycoderma from shock in, United Kingdom, 502
complications: Sheehan's syndrome, [Taylor] 889—ab
hemorrhage in, from fibrinogen depletion, [Klein] 711—ab
postpartum instructions, 816
PULMONARY VALVE
stenosis and ventricular septal defect with arteriovenous shunts, [Callahan] 1173—ab
stenosis with intact ventricular septum, surgery for, [Silverman] 1095—ab
PULSE
cranivascular volume tracings in headache, [Brazil] 1535—ab
pulseless disease, [Boccardelli] 1261—ab
PURPURA
Schönlein-Henoch's experimental, France, 1539
Schönlein-Henoch, 45 cases, [Sánchez Medal] 1062—ab
Schönlein-Henoch, immunologic disease? [Kreidberg] 602—ab

PURPURA—Continued
Schönlein-Henoch, prednisone and prednisolone for, England, 226; [Nabarro] 239—ab
thrombopenic, after acetazolamide, [Reisner & Morgan] *296
thrombopenic, joint pain after splenectomy, treatment, 1438
thrombopenic, with radial aplasia, Austria, 1161
PYELONEPHRITIS
vascular obstruction relation to hypertension in, [Kincaid-Smith] 812—ab
PYLORUS
stenosis, histology, Brazil, 225
stenosis, infantile hypertrophic, in parent and child, [McKeown] 916—ab
stenosis, pressure sound for, Austria, 1348
tumors, palpable contractile, in the newborn, [Craig] 916—ab
PYORRHEA: See Periodontal Disease
PYREXIA: See Fever
PYRIDOSTIGMINE BROMIDE
treatment of myasthenia gravis, [Tether] *156
PYRIDOXINE HYDROCHLORIDE
in anesthesia for ambulatory fracture treatment, Peru, 1231
treatment for nausea and vomiting in pregnancy, (Council report) *208
PYRIZIDIN: See Isoniazid

Q

QUACKERY
FDA warning on Boxsey cancer treatment, 1422
mechanical, A.M.A. pamphlet on, 1333
QUARTERLY CUMULATIVE INDEX MEDICUS: See American Medical Association
QUESTIONNAIRE
advisability of Eisenhower running for 2nd term, A.M.A. opposes answering, 52—E
QUINACRINE
treatment of Dipylidium caninum infection in man, 89
treatment of discoid lupus erythematosus, [Leeper] 1001—ab
treatment of rosacea, [Brodthagen] 1001—ab; (United Kingdom) 1552
treatment of Taenia saginata, 518
QUINOLINE: See Chloroquine; Iodoquinolines
QUINUA: See Vegetables

R

RABBIT FLEAR, myxomatosis from, United Kingdom, 1552
RABIES
control, vaccine with hyperimmune serum, Switzerland, 560
ultraviolet irradiated vaccine, France, 133
WHO-sponsored treatment, 1254
RACES: See Negroes
RADIATION
beta-rays for nevus flammeus, other treatment? 1100
biology, new course at Duke U., 403
hazard, leukemia? 151
hazards to neuradiologists from x-ray, [Ritvo & others] *1
of diencephalon in asthma, [Jacquelin] 918—ab
resection with, for bronchial cancer, [Bromley] 146—ab
rotatory, in inoperable lung cancer, [Thoms] 336—ab
therapy status in leukemia, (Council report) *1228
RADIO
A.M.A. Bureau of Health Education plans, 296
A.M.A. forms Physicians' Advisory Committee, 1147; 1322
A.M.A. transcriptions on "Common Cold," 1333
medical questions on, United Kingdom, 1256
physician and medical societies relation to, [PRobism Corner] *68
physician anonymity, British Medical Ass'n. examines, 1531
RADIOACTIVE: See also Atomic Bomb; Atomic Energy
carbon in tyrosine to study melanomas, Switzerland, 414
Chromium: See Chromium, radioactive
Gold: See Gold, radioactive
Iodine: See Iodine, radioactive
Isotope techniques (Oak Ridge course) 65; (U. of Southern California course) 300
Isotopes and surgery for brain tumors, Austria, 1086
Isotopes in medicine, international symposium, 1086
Isotopes manufacturing center for scientific and industrial use, United Kingdom, 798
level (low) in Columbia River, effects of, [Henderson] 1180—ab
materials, internal deposition of, [Looney & Cuodzin] *1
Phosphate: See Phosphate

RADIOACTIVE—Continued
Phosphorus: See Phosphorus
Sulfate: See Sulfates
Vitamin B12: See Vitamins B12
RADIO-IODINATED (I131) SERUM ALBUMIN (Human)
to study protein reactions, Austria, 1086
RADIOLOGY
practice by Iowa hospitals illegal, 53—E; [Medicine and the Law] 58
RADIUM
before hysterectomy vs. surgery alone for endometrial cancer, [Smith] *1460
late follow-up of internal deposition, [Looney & Cobodzin] *1
skeletal lesions following internal administration, [Marshak & others] *61
treatment, cervical cancer reappears 30 years after, [Hawkins] 999—ab
RADIUS
aplasia with thrombopenia, Austria, 1161
fractures, Monteggia, [Mobley] 142—ab
fractures, tylclal, [Eldstrom] 307—ab
traumatic dislocation of head in children [Stelling & Cote] *732
RADON
seed implants for liver metastases? 727
RAUDIXIN: See Rauwolfia serpentina
RAUPINA: See Rauwolfia serpentina
RAUWILOID: See Rauwolfia serpentina
RAUWOLFIA SERPENTINA (alseroxylon; rauwolfia; reserpine)
effect on gastric secretion, [Haverback] 828—ab
treatment, danger of combining with electric shock, (reply) [Epstein] 503—C
treatment, effects on nervous and cardiovascular systems, [Lewis & others] *622
treatment of eclampsia, [Cossutta] 82—ab
treatment of heart disease, [Schumann; Halpern] 705—ab
treatment of hypertension, (variables in evaluation) [Shapiro] *30; (depression from, France) 581; [Coan] 593—ab
treatment of mental defectives, Denmark, 500; [Jensen] 913—ab
treatment of mental disorders, [Hewat]; (chlorpromazine compared) [Kovitz] 143—ab; [Zeller & others] *179; [Toraguno] 812—ab; (Italian symposium on) 697
treatment of senile behavior, [Ferguson & Funderburk] *259
treatment of thyrotoxicosis, [Moncke] 705—ab; [Ottaviani] 804—ab
treatment of toksmia of pregnancy, [Balassi] 82—ab; (effect on infant) [Finnerty] 997—C; [Rogers] 1090—C
treatment plus amphetamine in obesity, [McNair] 231—ab
treatment plus methium chloride in hypertension, [Crawley] 705—ab
treatment plus veratrum in toxemia and hypertension in pregnancy, [Veskian] 999—ab
READ, LEONARD, E., address by: snowballing social security, [Public Relations] *485
RECRUITS: See Navy, U. S.
RECTUM
anastomosis to, for exstrophia of bladder, Austria, 1348
burns from decomposed paraldehyde, [Agranat] 352—ab
cancer, abdominoperineal proctosigmoidectomy with sphincter preservation for, [Bacon] *628
cancer and heart disease with electrolyte imbalance, diarrhea, adrenal insufficiency, and pulmonary edema, (Diagnostic Problems) [Frazier] *774; (comment) [Bay] *775
mercurial diuretic by, for congestive heart failure, [Makous] 903—ab
ulcers, urethinol for, [Brown & others] *360; 392—E
REFLEX
phenomena in etiology of surgical cardiac arrest, [Briggs & others] *1439
REFRACTION: See Eyes
REFRIGERATION
for amputations and tissue preservation, [Crosman] 1002—ab
REHABILITATION
for ataxia of arm, hand, and foot after brain surgery, 1185
for handicapped Puerto Ricans in U. S., 403
vocational, for mentally retarded or cerebral palsied, 403
workshop, applications accepted, N. Y., 883
REITER'S SYNDROME
treatment, ACTH and cortisone, [Foxworthy] 985—ab
RELAXANTS: See Muscles
RELIGION: See Faith
REPRINTS
enclose return envelope for, [Sterling] 801—C; (reply) [Davidsohn] 1533—C
RESCINNAMINE: See Rauwolfia serpentina
RESEARCH
A.M.A. grants-in-aid, 1147
Army Center moved from Tokyo to Camp Zama, (photo) 1156
grants, USPHS processing, 1527

RESEARCH—Continued
Indian Council on Medical Research convention, 796
Kimble Methodology Award, nominations requested, 1151
Lilly (Eli) South African Fellowship, [Shapiro] 587—C
medical, (Ireland) 797; (Israel) 993
medical, and William Harvey, [Katz] *1137
medical, comments on President's recommendation for increased government aid, [Davidsohn] 1091—C
medical, trends in, [Shannon] *1029
National Science Foundation grants, 1312
new journal: *Revue française d'études cliniques et biologiques*, France, 1253
significance of facts, guest editorial by Dr. Starr, 672—E
value of autopsy, guest editorial by Dr. Starr, 1144—E
RESERPINE: See Rauwolfia serpentina
RESIDENTS AND RESIDENCIES
allergy residencies available, (at Ohio State) 303; (at Northwestern) 488
for Indian doctors, Indian Medical Ass'n. requests, 884
number, 159:251, Sept. 24, 1955; (supplementary list and corrections) 160: 212, Jan. 21, 1956
resedencies available at VA hospitals, (neurologic and psychiatric) 309; (in otolaryngology) 495
RESINS
urea-formaldehyde, in facial tissues, allergy to, [Peck & Palitz] *1226
RESOCHIN: See Chloroquine
RESPIRATION
artificial, curarization and tracheotomy for severest tetanus, [Mollaret] 86—ab
artificial, via uncuffed tracheostomy tube, [Mörch & others] *864
breath-holding spells, [Hinman] 915—ab
carbon dioxide and altitude effects on, Peru, 315
chronic progressive failure, guest editorial by Dr. Sadove, 876—E
depression from alphaprodine, levallorphan prevents in anesthesia, [Foldes & others] *168
intermittent positive-pressure, with bronchodilators in pulmonary emphysema, [Leslie & others] *1125
RESPIRATORY SYSTEM
infection (acute), incidence, United Kingdom, 799
infection, care of tympanum perforation with suppuration during, 817
infection, epidemic in children, United Kingdom, 1255
infection with agammaglobulinemia, 920
London fog and chest complaints, 585
obstruction, medical treatment, [Davison] *105
obstruction, tracheotomy for, [Georgiade & others] *940
pathology in fibrocystic pancreas, [di Sant'Agnese] *846
upper, immunization of, [Walsh] 513—ab
REST
in tuberculosis of lung, [Breathnach] 707—ab; (energy expended, United Kingdom) 1532
RETCHING
postanesthetic: dimenhydrinate, chlorpromazine, and pentobarbital sodium for, [Knapp & Beecher] *376
RETICULO-ENDOTHELIAL SYSTEM
thorium deposition in, [Looney & Colodzin] *1
RETINA
detachment from recurrent uveitis? 1374
fat embolism after trauma, [Kearns] 1370—ab
transilluminators and retractors for detachment, [Berens] 159: 1532, Dec. 17, 1955; (correction) 160: 492, Feb. 11, 1956
RETINITIS
diabetic, value of Rutin for, (reply) [Krakowka] 610
macular edema (recurrent) with; heredomacular degeneration vs. central serous retinopathy, (reply) [Gordon] 610
RETIREMENT
age, Nuffield Foundation to study, United Kingdom, 798
voluntary pension plans for the self-employed, Jenkins-Keogh bills explained, [Keogh] 1234
RETRACTORS
for retinal detachment and surgery, [Berens] 159: 1532, Dec. 17, 1955; (correction) 160: 492, Feb. 11, 1956
RETROLENTAL FIBROPLASIA
eliminate by oxygen restriction, [Guy] 1536—ab
REULING, JAMES R., U. S. representative to WHO, 1322
RH FACTOR: See Hemolytic Disease of Fetus and Newborn
RHEUMATIC FEVER
blood antistreptolysin and streptococcal antihyaluronidase in, [Harris] 1096—ab
capillary microscopy of conjunctiva and nailbed in, [Davis] 709—ab
Cardiac Complications: See Heart disease: Heart inflammation
chronic, in woman 47, treatment, question of diagnosis, 921
Greenville Clinic reestablished, S. C., 571
history with low fever, should you treat for subacute bacterial endocarditis? 609
international symposium, April 30-May 3, Mexico City, 1421
low calorie diet for, patient died, naturopath criticized, United Kingdom, 1352
malignant cardiac, France, 1163
prevent, benzathine penicillin G for carriers of streptococci, [Brooks & Moe] *162
prevent by treating streptococcic infections, [Morris & others] *114
prevention, free benzathine penicillin G, Mich., 569
prevention, throat bacteria during, [Miller] 1261—ab
treatment, ACTH and cortisone, cardiologic effects, [Harris] 1095—ab
treatment, prednisone, Switzerland, 414
treatment, sodium salicylate plus glucose, [Perosa] 514—ab
RHEUMATISM
histamine to combat stress in, [Peristein] 708—ab
in infancy, [Segagni] 1177—ab
inflammatory, and tonsillectomy, France, 1163
pathology of skin nodules in, cortisone aided, 818
Rheumatological Roman Days, 4th, 66
treatment, phenylbutazone, [Denko] 708—ab
treatment, salicylamide vs. aspirin, (replies) [Salamon] 703—C; [Margolis] 800—C
treatment, zoxazolamine, [Smith & others] *745
RHINITIS
allergic, prednisone for, [Feinberg & Feinberg] *264
perennial, food causes, [Derlacki] 1436—ab
RHINORRHEA
cerebrospinal, after injuries, how long wait to do submucous resection? 151
RIBS
fractured, alleged neglect reported to liability committee, Sweden, 413
hydrocortisone for Tietze's syndrome, [Cello] 241—ab
surgical treatment of Tietze's syndrome, [Nix] 241—ab
tumors, primary, [Barrett] 713—ab
RICKETS
aminoaciduria in children with, France, 1350
RIGIDITY
improves with ethopropazine hydrochloride in paralysis agitans, [Doshay & others] *348
quantitative measurement in paralysis agitans, [Agate & others] *352
RIMIFON: See Isoniazid
RINGWORM: See Dermatophytosis; Tinea
RITALIN: See Methyl Phenylpiperidylacetate
ROBIN'S SYNDROME
micrognathia and glossoptosis, [Jaso] 811—ab
ROENTGEN RAYS
abnormalities of intestine after prolonged cathartic use, [Heilbrun] 246—ab
Chest x-rays: See Thorax, chest x-rays
dangers after pneumothorax or pneumoperitoneum for tuberculosis, United Kingdom, 585
diagnosis of abdominal tuberculosis in children, [Dittrich] 906—ab
diagnosis of retained surgical sponges, (reply) [Grunstein] 801—C
diagnosis of traumatic dislocation of radial head in children, [Stelling & Cote] *732
evaluation of low back pain, [Landry] 606—ab
findings in regional enteritis [Marshak] 606—ab
for fitting shoes hazardous? 1185
hazards to nonradiologists in examinations, [Ritvo & others] *4
in etiology of herpes zoster, [Seelentag] 918—ab
navy correspondence course on, 1156
of whole body in swine, STH effects, [Baxter] 515—ab
patterns of hyaline membrane and fetal aspiration syndromes, [Petterson] 148—ab
pelvimetry using single film, [Thoms & Billings] *448
planigraphy to diagnose lung nodule, [Rigler] 335—ab
signs (extraintestinal) of intestinal lipodystrophy, [Kyler & Doub] *534
study after using high-fluoride water, [Leone] 148—ab
study of gastrointestinal tract of the newborn, [Carbonell Juanico] 602—ab
ROENTGEN THERAPY
before hysterectomy vs. surgery alone for endometrial cancer, [Smith] *1460
cancer caused by, [Beutel] 918—ab
ROENTGEN THERAPY—Continued
David Anderson-Berry Medal of Royal Society of Edinburgh, 687
nitrogen mustard with, for lung cancer, [Hatch & others] *1129
of alcohol sensitivity in Hodgkin's disease, [Godden & others] *1274
of breast cancer before surgery, microscopic findings, [Grill] 1180—ab
of bronchial cancer, [Blanshard] 246—ab
of cerebral glioma, [Campi] 1368—ab
of puerperal mastitis, [Rossi] 514—ab
vs. hormones for metastatic breast cancer, (reply) [Garland] 586—C
vs. hydrocortisat in arthrosis of knee and hip, [Rasmussen] 712—ab
ROSACEA
treatment, mepacrine and chloroquine, [Brodthagen] 1001—ab; (United Kingdom) 1352
ROWNTREE, GRADIE R., receives President's Committee on Employment of Physically Handicapped Award, (photo) 677; 783
ROXINIL: See Rauwolfia serpentina
ROYAL COLLEGE
of Obstetricians and Gynecologists, libelous newspaper article on, 1256
of Surgeons cancer symposium, 501
RUBELLA
as cause of mental deficiency, [Kirman] 420—ab
RURAL COMMUNITIES
economics of prescribing drug samples in, United Kingdom, 1167
having no physician, warning against imposters in, Nebraska, 216
mobile school for postgraduate medical education, [Warner & Bowers] *1308
National Conference on Rural Health (11th), program, 594
sarcoidosis epidemiology relation to, [Gentry] 721—ab
RUSSIA
albomycin, antibiotic discovered in, 226; [Gause] 332—ab
Russian doctors visit Great Britain, 74
scientists study poliomyelitis therapy and Salk vaccine in U. S., 404
RUTIN
treatment questionable in diabetic retinitis, (reply) [Krakowka] 610

S

STH: See Somatotropin
SABOURAUD'S MEDIUM
office mycological diagnosis using, [Robinson & others] *537
SACCHARIN
as sweetener, (Council statement) *875
SACROILIAC JOINT
arthritis and narrowing in intestinal lipodystrophy, [Kyler & Doub] *534
sprain or strain, low back pain from, [Diveley & others] *729
SADOVE, MAX S., guest editorial: chronic progressive respiratory failure, 876—E
SAINT'S TRIAD
hiatus hernia, gall stones and diverticulosis coli, surgery for, [Palmer] 241—ab
SALAZOPYRIN
for hemorrhagic colitis, Switzerland, 1350
SALICYLAMIDE
as analgesic and antirheumatic agent, (replies) [Salamon] 703—C; [Margolis] 800—C
treatment of recurrent urolithiasis, [Prien & Walker] *355
SALICYLATES
carbazochrome salicylate, N.N.R., 119
digitalis, sedation and; vs. corticosteroids in rheumatic carditis, [Wilson & Lim] *1457
treatment of recurrent renal calculi, [Baker & Connelly] *1106
treatment plus succinate in arthritis, [Gilpin] 1261—ab
1-SALICYLIDENE-2-ISONICOTINYL HYDRAZINE
treatment of tuberculosis, Ireland, 797
SALIVA
stimulated in auriculo-temporal syndrome, [Gardner & McCubbin] *272
SALIVARY GLANDS
pathology in fibrocystic pancreas, [di Sant'Agnese] *846
SALIZID: See 1-Salicylidene-2-Isonicotinyl Hydrazine
SALK Vaccine: See Poliomyelitis
SALMONELLA: See also Eberthella
food poisoning from, 291—E
SALMONELLOSIS
treatment, chloramphenicol, India, 893
SALT: See also Sodium chloride
Free diet: See Sodium restriction
iodized, to prevent goiter decreases deaf-mutism, Switzerland, 995
SAMPLES
drug, especially vitamins requested for the Navajos, [Cullen] 415—C
drug, request for Korean hospital, especially for tuberculosis, [Codington] 232—C
prescribing by rural physicians, economic problems in, United Kingdom, 1167

SAN FRANCISCO: **SAN MATEO**: See California
SANAMYCIN: See Actinomycin C
SANATORIUM: See Tuberculosis
SANITATION
citation to American Export Lines of New York City, 687
in civil defense planning and requirements, [Whitney] *1195
N. Y. code amended on milk from brucellosis-free cows, 123
SARCOCYSTITIS
in human beings, India, 75
SARCOIDOSIS
diagnosis, Kveim reaction, [Israel] 592—ab
epidemiology relation to soil and urban-rural residence, [Gentry] 721—ab
pulmonary, cortisone for, France, 695
SARCOMA
reticulum cell, actinomycin C for, [Trounce] 567—ab; [Croizat] 684—ab
reticulum cell, *p*-(di-2-chlorethyl-amino)-phenylbutyric acid for, England, 1327; [Galton] 331—ab
SARPANKH JUICE
effect on blood sugar, India, 686
SCABIES
Norwegian, pathogenesis, Vitamin A deficiency in, France, 580
SCAR: See Cicatrix
SCARLET FEVER
treatment, spiramycin and erythromycin; diagnosing benign forms, [Martin] 685—ab
SCHMITZ TONOMETER
Bernese-Tolman tonometer compared, [Cholst & Horovitz] *661
SCHISTOSOMA
in snails, copper ricinoleate to control, Brazil, 72
SCHISTOSOMIASIS
in rats, organ pathology in, Brazil, 1427
morbidity among Yemenite immigrants, Israel, 581
SCHIZOPHRENIC REACTIONS
adrenocortical function in, [Bliss] 81—ab
art exhibit of patients, England, 74
treatment, chlorpromazine and reserpine, [Kovitz] 143—ab; [Zeller & others] *179
treatment, insulin shock in diabetics, Austria, 598
SCHOENLEIN-Henoch Purpura: See Purpura
SCHOLARSHIPS
American Hearing Society, in lip reading, 572
Citterman (Solomon), first, 122
in alcoholism at Yale, 784
in Public Health at Harvard, 572
Life and Casualty Insurance Company, annual at Vanderbilt, 124
National Medical Ass'n., 61
Vermont Tuberculosis and Health Ass'n., postgraduate, 571
SCHOOLS
for medical secretaries, Denmark, 1162
health implications of White House conference, 120—E
health in, Joint Committee on Health Problems in Education is preparing book on, 1323
Jonas E. Salk, new school for Anaheim, Calif., 1335
mysterious illness at, England, 315
named for Dr. J. H. Hess, Chicago, 982
nursery, poliomyelitis in, [McCarroll] 690—ab
veterinary, Queen visits, England, 258
SCHOOLS, MEDICAL
Alumni: See Graduates
Commonwealth Fund and Ford Foundation grants, 210—E
early professorships in surgery, [Ascher] 415—C
faculty appointments and private practice, 979
faculty, general practitioners, United Kingdom, 896
faculty salaries, United Kingdom, 1429
filling gap between medical practice and, [Stone] *1290
financial problems, encourages support for A.M.E.F., President Hess' page, 1146
foreign, committee on graduates of, report, 978
Korean, books for: shipping instructions, 572
let's save university hospitals for clinical training, [Cutler] *282
Medical Education Week, 1410—E
mobile, for postgraduate education, [Warner & Bowers] *1306
research in, comments on President's recommendation for increased government aid, [Davidsohn] 1091—C
research in, financial support for [Shannon] *1029
SCHULLER-CHRISTIAN SYNDROME
lung changes in unusual case, [McNeill] 906—ab
SCIATICA
complicating brucellosis, India, 993
pain from thoracic and cervical spinal tumors simulating, [Scott] *528
SCIENCE
discoveries by medical students, [Carter & Luckhardt] 504—C
fairs, A.M.A. program, [Public Relations] *59; (awards) 781
National Research Council-AAAS program to increase output of scientists, 66
SCLEREMA
neonatorum, ACTH for, [Nuñez] 1177—ab
SCLERODERMA
diffuse, prednisone for, [Rodnan] 905—ab
diffuse, with visceral signs, [Piper] 244—ab
SCLEROSIS
of bones following radium internally, [Marshak & others] *41
progressive systemic; visceral signs in scleroderma, [Piper] 244—ab
SCLEROSIS, MULTIPLE
familial occurrence, [Estborn] 998—ab
smoking adversely affects, United Kingdom, 585
treatment, phenothiazine, [Seyffert] 998—ab
treatment, roxazolamine, [Rodrigues-Gomez & others] *752
SCORPIONS
sting in 19-month-old infant, hemolymph from scorpion for, Israel, 581
SCOTTIE PHONE AID
portable amplifier, [Boomer] *285
SCROTUM
burning sensation in, after transurethral resection; cause and treatment, 340
SEASICKNESS: See Motion Sickness
SEBORRHEA
selenium sulfide for, N.N.R., 51
SECRETARIES
medical, schools for, Denmark, 1162
SECURITY SUPERVISORS, A.M.A. selects as investment advisors, 1147
SEDATIVES: See Hypnotics
SELENIUM SULFIDE
for seborrheic conditions, N.N.R., 51
shampoo, hair loss from, [Grover] *1397
SELF-MEDICATION
what mothers prescribe for their infants, England, 73
SELSUN: See Selenium Sulfide
SEMEN
amino acids level in various levels of infertility, [Tyler & Singher] *91
SEMENOLYSIS
in hemorrhagic diathesis with prostate cancer, [Prout & others] *840
SEQUESTRATION
of lungs, aortography to diagnose, [Kenney & Eyler] *1464
SEROTONIN: See 5-Hydroxytryptamine
SERPASIL: See Rauwolfia serpentina
SERPINA: See Rauwolfia serpentina
SERUM
age factor in influenza antibodies in, postepidemically, [Hennessy] 320—ab
colloidal gold test to diagnose struma lymphomatosa, [Shirpan] 334—ab
sickness, cortisone and ACTH for, [Fitzgerald] 863—ab
sickness, prednisone for, [Feinberg & Feinberg] *264
SEWAGE
infectious agents in, after disposal plant treatment, 877—E
Shigella survival in, [Wang] 1371—ab
SEX
activity in psychomotor epilepsy, France, 580
factor in mortality of hypertension with cardiovascular disease, [Smithwick & others] *1023
factor in sweating, Switzerland, 414
in aniridia sex-linked? 423
SHAMPOO
Selsun, hair loss from [Grover] *1397
SHAVING
eyebrows prevent their regrowth? 816
SHEEHAN'S Syndrome: See under Pituitary
SHEEP
hypothermia in, for experimental cardiovascular surgery, N. Z., 229
SHIGELLA
survival in sewage, [Wang] 1371—ab
SHIPS
transport, drugs to protect against motion sickness, *755; (correction) 1091
SHOCK
collapse with cyanosis in a diabetic, nervous involvement likely, 689
dilutional hyponatremic, in transurethral prostatectomy, [Harrison] 1426—ab
hemorrhagic, hydrodextran for, [Harrison] 79—ab
in old age, blood amineopherase in, [Merrill & others] *1454
postpartum, primary myxedema from, United Kingdom, 502
sudden, in infant from exsanguinating hemorrhage, 688
traumatic, [Laborit] 898—ab
SHOES
conductive, help in conductive floors in hospitals? 1099
fitting with x-rays hazardous? 1185
SILICOSIS: See Pneumoconiosis
SILICOTE: See Dimethicone
SILVER
tracheostomy tube, [Mörch & others] *864
SINUS
longitudinal, in infants, thromboses of, [Bustamante] 718—ab
SITOSTEROLS
N.N.R., 671
SKELETON: See Bones
SKIN
cancer and precancerous lesions, cystostatic pomades for, Switzerland, 995
cancer, terebrating, of scalp and forehead, Austria, 1161
cap arthroplasty of hip, Finland, 580
defects, planing for, [Grais] 602—ab
disease, hydrocortisone ointment for, [Mullins] 244—ab; (India) 797
Disease (Industrial): See Industrial Dermatoses
disease (menstrual), vitamin E in, Switzerland, 995
disease, prednisolone for, [Frank] 245—ab
eruptions, office mycological diagnosis, [Robinson & others] *537
eruptions, pigeons shed parasites that cause? 341; (reply) [Burgess] 1186
grafts for Dupuytren's contracture, [Conway] 240—ab
grafts (homo-), halocortisols and prednisone effects on, N. Z., 229
grafts in psoriasis, 1004
grafts (iso- and auto-) for electric burns, death on 63rd day, Austria, 132
grafts (postmortem homo-), preserving, [Brown] 598—ab
Inflammation: See Dermatitis; Dermatomyositis
nodules in rheumatism, pathology, cortisone aided, 818
pigment, in Peutz-Jeghers syndrome, [Freeman] 327—ab
radiation hazards to nonradiologists, [Ritto & others] *1
testing of industrial compounds, polyvalent sensitivity developed, [Von Haam] 603—ab
tests of allergy to tissues with urea-formaldehyde resin, [Peck & Palitz] *1226
tests of neomycin negative, contact dermatitis after, [Epstein] 1355—C
tests positive, anaphylactic penicillin reactions in, [Peters] 1178—ab
traction, legging for, [Anderson & Robbins] *1315
tumors, leiomyosarcoma with lymphatic spread, [Levack] 242—ab
SKINNER, CORNELIA OTIS
National Conference of Christians and Jews welcomes, (photo) 305
SKULL: See Cranium
SLEEP
behavior in old age, United Kingdom, 1168
therapy for acute phase of poliomyelitis, [Brehme] 80—ab
therapy in ophthalomology, France, 1428
SMALLPOX
accidental vaccination after exposure to fresh vaccination, 836
vaccination and poliomyelitis immunity, United Kingdom, 1167
vaccination, encephalitis rare after, France, 1350
SMITH, KLINE AND FRENCH LABORATORIES
co-sponsor "March of Medicine," 1147
SMITHWICK'S lumbosacral sympathectomy for hypertensive vascular disease, [White] *1027
SMOKE
less, and more dust in air over Britain, 702
SMOKING: See Tobacco
SNAILS
copper ricinoleate to control schistosomes in, Brazil, 72
SOAP: See also Shampoo
antiseptic allergy to, [Blank] *1225
SOCIAL CONDITIONS
interclass marriages, United Kingdom, 897
poliomyelitis at high socioeconomic level, [Nolan] 512—ab
social pediatrics course in Paris, 883
socioeconomic distribution of lung cancer, [Cohart] 722—ab
SOCIAL SECURITY
amendments on disability benefits, hearings on, 1056—E; 1058
for physicians, A.M.A. opposes compulsory not voluntary, (President's Page) 293
reciprocal agreement between United Kingdom and New Zealand, 898
snowballing, [Public Relations] *485
voluntary pensions for the self-employed, Jenkins-Keogh bills explained, [Keogh] 1234
SOCIAL WELFARE vs. Peruvian Medical Ass'n. on medical service plans, 1164
SOCIETIES, MEDICAL: See also list of Societies at end of letter S
Alameda-Contra Costa Diabetes Ass'n. dedicated, Calif., 1335
American-Hungarian Medical Ass'n. sesquicentennial, 1243
A.M.A. study of professional liability insurance, [Medicine and the Law] *395

SOCIETIES, MEDICAL—Continued
Broome County, 150th anniversary, N. Y., 1149
College of American Pathologists move office, 1245
county, activities, A.M.A. survey, 296; (Council report) *564
Eastern Psychiatric Research Ass'n. founded, 786
Executives Conference (program) 56; (papers read) [Kirklin] *1327; [Mortensen] *1329; [Norby] *1331
grievance committees, A.M.A. publications on, 296; 1235
Harris County (Texas) plan of mobile support for civil defense, [Olson & others] *1202; [Howard & others] *1211
Hawaii Medical Ass'n. centennial, 786
Hawaiian Society of Anesthesiologists formed, 786
maternal mortality study by Columbus (Ohio) Obstetric-Gynecologic Society, (Council article) *296
Michigan State honors Los Angeles County for "Medic," (photo) 121
need for better press relations, [Wilmer] *768
New York County, 150th anniversary, 1243
Onondaga County, 150th anniversary; Dr. Hess to speak, N. Y., 1243
participation in, by younger physicians encouraged, (President's Page) 293
participation in, promotes better public health, [Pinckney] *1450
Pediatric Society of Central New Jersey formed, 1078
relation to press, radio, and television, [Problem Corner] *60
role of executives conference, [Mortensen] *1329
San Mateo County (Calif.) studies medical newspaper coverage, [Wilmer] *663; *768 (replies) [McDowell; Wren] 1236; [Ford] 1237; (reply) [Wilmer] 1237
Scott County, centennial, Iowa, 983
Society of Pathological Anatomy founded, Peru, 698
state placement services, [Council article] *1414
Tennessee State Medical Ass'n. move offices, 686
Utah Trudeau Society formed, 686
Western Association of Physicians formed, 1152
SOCIETY OF ACTUARIES life insurance mortality studies, [Bolt & Lew] *736
SODIUM
Acetrizoate: See Acetrizoate, Sodium
Chloride: See also Salt
chloride in hydrotubation, [Yagi] 328—ab
chloride in sweat in fibrocystic pancreas, [di Sant'Agnese] *946
chloride, radioactive, to study blood flow in pregnancy, Austria, 1088
dilutional hyponatremic shock in transurethral prostatectomy, [Harrison] 1436—ab
Diprotrizoate: See Diprotrizoate
hydroxide burns of esophagus, management, [Carver & others] *1447
in blood and urine, test for adrenocortical insufficiency, [Perlmutter] *117
Iodipamide: See Iodipamide, Sodium
lactate (molar) in heart block and arrest, [Bellet] 237—ab; [Bellet & others] *1293
levothyroxine, tests and standards, 1054
Radio-phosphate: See Phosphate
radiosodium clearance, Austria, 1087
Radiosulfate: See Sulfates
restriction to control uremia and eclampsia, [Falls] *251; (reply) [Allen] 997—C
restriction, variables in evaluating hypotensive effect, [Shapiro] *30
salicylate plus glucose for rheumatism, [Perosa] 514—ab
Thyroxine: See Thyroxine
SOIL
carcinogens in, United Kingdom, 1353
sarcoidosis epidemiology relation to, [Gentry] 721—ab
SOLU-CORTEF: See Hydrocortisone sodium succinate
SOLVENTS
in etiology of occupational dermatoses, [Klauder] *442
lower nephron nephrosis from, kidney biopsy in, [Casey] 330—ab
SOMATOTROPIN (STH): somatotropic hormone) effect on swine exposed to whole body x-irradiation, [Baxter] 515—ab
SOMATOTYPES: See under Body
SOMNIPHEN
for rest in acute poliomyelitis, [Brehme] 80—ab
SOUTH AFRICA
College of Physicians and Surgeons of South Africa incorporated, 228
SPASM
treatment, zoxazolamine, [Rodriguez-Gomez & others] *752
SPECIALTIES
approved residencies and fellowships by, 159: 251, Sept. 24, 1955; (supplementary list and corrections) 160:212, Jan. 21, 1956
general practice relation to, [Friery] 1257—C
in reintegration of medicine, 1472—E
specialists fees in N.H.S., for home consultations, England, 227
Specialty Boards, [Kirklin] *1327
study of medical school alumni, (Bureau article) [Dickinson] *473
time after graduation relation to specialization, [Terris & Monk] *653
training by accretion or by design? [Comroe] *1323
training in Brazil, (correction) 587—C
trends, survey, [Weiskotten] *1303
SPEECH
defects, stuttering, guest editorial by Dr. Blanton, 1472—E
SPERMATOZOA
sperm in during coitus, can man be helped? 249
male infertility, testosterone for, [Charny] *98
male infertility; treatment, prevention and research, [Tyler & Singher] *91
not produced in undescended testis, surgery for, [Gross & Jewett] *634
SPHEROCYTOSIS
hereditary, [Stenstrom] 803—ab
SPHINCTER MUSCLES
anal, preserve in abdominoperineal proctosigmoidectomy for rectal cancer, [Bacon] *628
Oddi's, inflammation, postcholecystectomy dyskinesia from, [Walters] *425
Oddi's, sphincterotomy for pancreatitis, [Doubilet & Mulholland] *521
SPIGELIAN HERNIA
4 cases, [Isaacson] 911—ab
SPINAL CANAL
myelography for leg pain simulating sciatica, [Scott] *528
pitfalls of myelography, [MacCarty] 335—ab
SPINAL CORD
cervical and high thoracic tumors causing leg pain, [Scott] *528
compression by neoplasms, early diagnosis, [Rice-Oxley] 681—ab
diseases, zoxazolamine for, [Rodriguez-Gomez & others] *752
lesions, exoskeletal splithook prostheses for, [Nyquist] *761
myelopathy from cervical spondylosis, diagnosis; treatment, [Northfield] 809—ab
SPINAL FLUID: See Cerebrospinal Fluid
SPINE
cervical disk pathology, surgical indications, Switzerland, 1428
cervical dislocation (partial) after pharyngitis, Austria, 794
cervical spondylosis, myelopathy from, [Northfield] 809—ab
cervical vertigo, [Ryan] 914—ab
etiology of pre-adolescent kyphosis, [Ferguson] 1060—ab
lumbar disk slips, surgery for; question value of fusion, (reply) [Davidoff] 610
lumbar disk syndrome, nonoperative treatment, [Mennor] 512—ab
lumbar herniated disks, "ventral hanging-through" for, [Weiss] 511—ab
lumbar ruptured disks, vertebral body fusion for; x-ray study, [Cloward] 511—ab
lumbar traction, eliminate factors preventing stretch, (reply) [Judovich] 1258—C
osteoarthritis, paravertebral cortisone for, (replies) [Pruce] 899—C; [Cohen] 1355—C
osteophytosis, clinical syndrome, [Bick] *828
protruded intervertebral disk in etiology of low back pain, [Diveley & others] *729
rheumatoid spondylitis and crippling fluorosis compared, [Steinberg] 1371—ab
rheumatoid spondylitis, zoxazolamine in, [Smith & others] *745
subluxation of cervical vertebrae, torticollis from, [Donaldson] *458
thoracic disk protrusions, [Abbott] 914—ab
tuberculosis, concomitant pain in back and abdomen, [Lewin] 1257—C
SPIRAMYCIN
clinical and laboratory studies, [Hudson] 1097—ab
new antibiotic, France, 695
treatment of scarlet fever, erythromycin compared, [Martin] 683—ab
SPLANCHNICECTOMY: See under Nerves
SPLENECTOMY
in Fanconi's anemia, [Francis] 145—ab
in lupus erythematosus, [Cardozo] 321—ab
SPLENOPORTOGRAPHY
percutaneous, [Adlercreutz] 337—ab
SPLINTS
Denis Brown, for pigeon-toed walk, (reply) [Starr] 90
Thomas, for osteochondrosis of capital epiphysis of femur, Austria, 794
SPLITBOOK PROSTHESIS
exoskeletal, for traumatic tetraplegia in arms, [Nyquist] *761
SPONDYLITIS: See Spine
SPONGE
polyethylene, and Perspex for extraperiosteal apicolysis with plombage, United Kingdom, 1532
surgical (retained), x-ray diagnosis, (reply) [Grunstein] 801—C
STAINING
of cervical and vaginal secretions to study endocrine function, 726
potassium hydroxide and ink for mycological diagnosis, [Robinson & others] *537
STAMPS: See Postage Stamps
STANDARD Nomenclature of Diseases and Operations: See Terminology
STANDISH, SEYMOUR, JR., and others, "Why Patients See Doctors," summary, (Bureau article) [Dickinson] *213
STAPHYLOCOCCUS
empyema, [Brownrigg] 328—ab
endocarditis after mitral valvulotomy, [Dalton] 1366—ab
enteritis from antibiotics fatal, Denmark, 412
food poisoning from enterotoxins from, 291—E
infection from milk powder, United Kingdom, 1436
infection in childhood, [Taft] 915—ab
nasal and fecal carriers in hospitals, [Brodie] 904—ab
pneumonia in infancy, [Wallman] 716—ab
puerperal mastitis from, (effects on infant) [Ferrario] 1369—ab; [Gunther] 1434—ab
STARR, ISAAC, guest editorials: (significance of facts) 672—E; (potential values of autopsy today) 1144—E
STATISTICS
double blindfold technique in evaluating drugs, (reply) [Best] 586—C
estimating operative risk, [Moyer & Kay] *853
interpreting in study of dimenhydrinate in postoperative vomiting, (reply) [Zeisler] 318—C
medical, unverifiable hypothesis of what would have happened if therapy differed, 563—E
on newspaper medical coverage, [Wilmer] *663; *768; (replies) [McDowell; Wren] 1236; [Ford] 1237; (reply) [Wilmer] 1237
significance of facts, guest editorial by Dr. Starr, 672—E
STELLATE Ganglion: See Ganglion
STERILITY, SEXUAL
cervical pathology in [Buxton] 144—ab
in men, testosterone for, [Charny] *98
in men, treatment, prevention and research, [Tyler & Singher] *91
pregnancies in infertile couples, [Keettel & others] *102
World Congress (2nd), Italy, May, 66
STERILIZATION, BACTERIAL
intestinal, recolonize with coli bacteria after, [Zettler] 242—ab
STERILIZATION, SEXUAL
for 2 primary cancers in breast? 1374
not necessary after 4 or more cesarean sections, [McNally & Fitzpatrick] *1005
STERNUM
marrow aspiration, cardiac tamponade after, [Jenkins] 326—ab
STEROID
anesthesia, [Gordan] 1002—ab; [Murphy] 1097—ab
copper-reducing, in urine of psychiatric patients, [Merivale] 599—ab
STETHOSCOPES
use by physical educators advised? 250
STILBAMIDINE
treatment of tic douloureux, (reply) [Smith & Miller] 1431—C
STILL'S Disease: See Arthritis, Rheumatoid
STOCKINGS: See Clothing
STOKES-Adams Syndrome: See Heart block
STOMACH
achylia and achlorhydria differentiated by radioactive vitamin B_{12} [MacLean] 79—ab
acidity reduced by Sustagen, [Winkelstein & Schweiger] *1111
cancer, [Shagon] 1534—ab
cancer, chymotrypsin lavage to diagnose, [Klayman; Rubin] 706—ab
cancer, perforated, subtotal resection for, [Bisgard] *363
cancer, surgery for, Swiss society discusses, 316
cardiospasm in children, [Palazzo] 243—ab
cardiospasm with dilatation of esophagus, (reply) [Vinson] 703—C
cardiospasm with esophagitis and hiatus hernia, [Boyd] 320—ab
esophageal junction disorders, [Texter & others] *830
gallstones in stomach from fistula, [Melamed & Parker] *463
hemorrhage from aspirin, United Kingdom, 897
inflammation, [Hodges] 605—ab

STOMACH—Continued
- inflammation relation to alcohol, United Kingdom, 1130
- marginal esophagogastric ulceration, [Wolf] 706—ab
- mucosa with intestinal metaplasia, cancer arising in, [Morson] 514—ab
- pancreatic tissue in, hemorrhage with, [Hudock] 910—ab
- physiology, British society discusses, 313
- secretion, reserpine and chlorpromazine effects on, [Haverback] 332—ab
- Surgery: See also Peptic Ulcer, surgical treatment; Stomach cancer
- surgery, Austrian surgeons discuss, 1251
- surgery, gastrectomy: anemia after, [Bademoch] 321—ab; [Boivin] 596—ab
- surgery, gastrectomy sequelae, France, 1350
- surgery, gastrectomy: tuberculosis of lung after, India, 695
- surgery of cardia, regurgitant esophageal ulcer after, [Schmidt] 237—ab
- surgery, resection for hemorrhage in old age, [Gilchrist & de Peyster] *1375
- syphilis with cancer, India, 695
- Ulcer: See Peptic Ulcer

STOMACH TUBE
- in pressure sound for pyloric stenosis, Austria, 1348

STOMATOLOGY: See Mouth

STORAGE
- changes in preserved blood for laboratory tests, 152

STREPTOCOCCUS
- group A beta-hemolytic, benzathine penicillin G for carriers, [Brooks & Moe] *162
- infections, prevent rheumatic fever by treating, [Morris & others] *114
- infectious nephritis and, [Wahl] 145—ab
- streptococcal antihyaluronidase in sera in rheumatic fever, [Harris] 1096—ab

STREPTOLYSIN: See Antistreptolysin

STREPTOMYCIN
- bacterial resistance, serial subculture in mixtures effects, [Molomut & others] *967
- Dihydro—: See Dihydrostreptomycin
- penicillin simultaneously, blood levels after, [Hassing] 509—ab
- toxicity: allergy fatal, [Hansen] 509—ab
- treatment of bone and joint tuberculosis, [Campos] 596—ab; [Smith] 597—ab
- treatment of peritonitis after appendicitis, 921
- treatment of pulmonary tuberculosis, bacilli resistance after, [Besta] 417—ab
- treatment of renal tuberculosis, [Lattimer & others] *544
- treatment of tuberculous bone or synovial infection, [Dougherty] 597—ab
- treatment plus isoniazid and/or PAS in pulmonary tuberculosis, [Tucker] 322—ab; 323—ab; (plus surgery) [Allen] 508—ab; [Hoyle] 707—ab; (United Kingdom) 1166
- treatment plus isoniazid in tuberculous meningitis, (plus hydrocortisone) [Cocchi] 1000—ab; (United Kingdom) 1254
- treatment plus liver and vitamins B in pulmonary tuberculosis, [Pozzi] 1262—ab
- treatment plus PAS in pelvic tuberculosis, 152
- treatment plus tuberculin before surgery in pulmonary tuberculosis, United Kingdom, 1255

STREPTOTRICHOSIS: See Actinomycosis; Nocardiosis

STRESS
- histamine to combat, in rheumatism, [Perlstein] 708—ab

STROBELIGHTS
- in operating room, explosion hazards in? 816

"STROKES": See Brain hemorrhage

STRONGYLOIDES
- stercoralis infestation, specific treatment? 151

STRONGYLOIDIASIS
- fatal, Brazil, 795

STRUMA
- Lymphomatosa (Hashimoto's Disease): See Thyroid

STUDENTS, MEDICAL
- junior and senior, Air Force educational program for, 129
- Levy Memorial loan fund at State U. of New York, 302
- naval research training program, 1527
- scientific discoveries by, [Carter & Luckhardt] 504—C
- Student A.M.A., reception for, 1323

STUTTERING: See Speech defects

SUBDURAL: See Meninges

SUCARYL: See Cyclamates

SUCCINATE
- treatment plus salicylate in arthritis, [Gilpin] 1261—ab

SUICIDE
- attempts by barbiturates, United Kingdom, 1351
- not a serious crime, United Kingdom, 702

SULFADIAZINE
- to prevent rheumatic fever, throat bacteria during, [Miller] 1261—ab

SULFADIAZINE—Continued
- treatment of recurrent winter sore throat with fever, 151
- treatment of streptococcic infections to prevent rheumatic fever, [Morris & others] *114

SULFAMETHYLTHIADIAZOLE
- treatment plus 2,6-diamino-3-phenylazopyridine hydrochloride in urinary infections, [Toland & Schwartz] *542

SULFATES
- labelled, uptake by cartilage homografts, [Wyburn] 325—ab
- sodium radiosulfate to determine extracellular water in hypertension and heart failure, [Walser & others] *858

SULFATHIAZOLE
- treatment of anthrax, 52—E

SULFOBROMOPHTHALEIN SODIUM
- retention test in intravenous cholangiogram, [Wise & O'Brien] *819

SULFONAMIDES
- hypoglycemic and antidiabetic, (France) 1089; (carbutamide) [Ridolfo & Kirtley] *1285; 1320—E; [Loubatières] 1536—ab
- isopropylthiadiazol orally in diabetes, Austria, 499
- to prevent measle complications, United Kingdom, 896
- treatment of purulent meningitis, [Aarsvold] 1265—ab
- treatment of urinary infections, 210—E; (reply) [Sherrod] 1091—C
- triple-, bacterial resistance, serial subculture in mixtures effects, [Molomut & others] *967

SULFONES
- treatment of leprosy, India, 75; 993

SUN
- blindness, local epidemic in Scotland, 1353
- sunburn possible through glass or plastics? 1438

SUPERSONICS: See Ultrasonics

SUPRARENALS: See Adrenals

SURGEON GENERAL'S Index-Catalogue closed, [Rogers] 801—C

SURGERY
- adrenal insufficiency during, treatment, [Howland & others] *1271
- blood volume determinations, [Meyer] *1312
- cancer-cell seeding of wounds, [Smith] 711—ab; [Crile] 1263—ab
- cholecystitis and peritonitis after unrelated surgery, (fatal) [Levin] *1040; [Glenn] 1263—ab
- deaths caused by, United Kingdom, 1353
- delay in seeking, [Titchener & others] *1187
- early professorships in, [Ascher] 415—C
- estimating risk, [Moyer & Key] *853
- gastroenterological, noncrushing clamp for, [Rienhoff] *1136
- healing of thoracic and abdominal wounds with or without dressings, [Palumbo & others] *553
- intestinal tubes for operative decompression and postoperative ileus, [Smith] *266
- masks covering nose necessary? 424
- operating room, air conditioner in, (reply) [Walter] 152
- operating room deaths from cardiac arrest, [Briggs & others] *1439
- operating room for tuberculosis safe for general surgery? 610
- operating room, nylon explosion hazard? 88
- operating room, strobelight explosion hazard? 816
- plastic, for breast hypoplasia, Austria, 1426
- Poços de Caldas, branch of International College of Surgeons, Brazil, 1427
- postoperative carbohydrate metabolism, Peru, 895
- postoperative convulsions, diphenylhydantoin sodium parenterally for, [Murphy & Schwab] *385
- postoperative enterocolitis, [Scholz] 1176—ab
- postoperative infections, tetracycline for, [Pulaski] 1097—ab
- postoperative intravenous fluids, Brazil, 225
- in, [Weyl] 149—ab
- postoperative lung edema, Alcohol inhalation
- postoperative nausea, vomiting and retching, drugs for, [Knapp & Beecher] *376
- postoperative paralytic ileus, pantothenic acid for, [Orecchia] 1367—ab
- postoperative vomiting, dimenhydrinate for: interpreting statistics, (reply) [Zeisler] 318—C
- preoperative diagnosis of lung sequestration by aortography, [Kenney & Eyler] *1464
- retained sponges, x-ray diagnosis, (reply) [Grunstein] 801—C
- surgeon's responsibility for paralysis after injection by nun, France, 1163
- tissue committee in hospital accreditation, [Medicine and the Law] *1238
- transilluminators and retractors for, [Berens] 159:1532, Dec. 17, 1955; (correction) 160: 492, Feb. 11, 1956

SUSTAGEN
- fluid nutriment for peptic ulcer, [Winkelstein & Schweiger] *1111

SUTURES
- suture control of bleeding duodenal ulcer, [Albright] 326—ab

SWALLOWING
- dysphagia, French congress discusses, 1349
- dysphagia from lower esophageal ring, [Schatzki] 1179—ab
- postapoplectic disturbances, Austria, 794

SWEAT
- gustatory, from misdirected regenerated auriculotemporal nerve, [Gardner & McCubbin] *272
- hemosiderin in epithelial cells of apocrine glands, test for hemochromatosis, Switzerland, 995
- in fibrocystic pancreas, [di Sant'Agnese] *846
- intensity relation to age and sex, Switzerland, 414

SWEDEN, epidemiological approach to larynx cancer etiology in, [Wynder & others] *1384

SWEETENERS
- artificial, (Council statement) *875

SWIMMING POOL
- with constant inflow and outflow, bactericide needed? 248

SWISS Society of Gastroenterology, 316

SYMPATHECTOMY
- indications for, in asthma, (reply) [Engelsher] 76—C
- indication for, in cerebral arteriosclerosis, [Murakami] 599—ab
- lumbodorsal, for hypertensive cardiovascular disease, [White] *1027
- perform by electric shocks? 817

SYNCOPE
- [Aarseth] 1366—ab

SYNOVIAL MEMBRANE
- tuberculosis, streptomycin for, [Dougherty] 597—ab

SYNOVITIS
- villonodular pigmented, amputate finger or excise tumor? 424

SYPHILIS
- diagnosis, Treponema pallidum immobilization of spinal fluid, [Miller & others] *1394
- diagnostic tests, autodeviation of complement in, Switzerland, 995
- of stomach with cancer, India, 695
- serodiagnosis, Treponema pallidum immobilization, (Switzerland) 994; [Ledbetter] *1392
- serotests positive with no disease in cook, danger of transmission? 1100
- tabes and general paresis incidence after early treatment, Switzerland, 995

SOCIETIES AND OTHER ORGANIZATIONS

Acad.—Academy	*Indust. Industrial*
Am.—American	*Inst.—Institute*
A.—Association	*Internat.—International*
Coll.—College	*M.—Medical*
Commn.—Commission	*Med.—Medicine*
Comm.—Committee	*Nat.—National*
Conf.—Conference	*Pharm.—Pharmaceutical*
Cong.—Congress	*Phys.—Physicians*
Dist.—District	*Soc.—Society*
Div.—Division	*Surg.—Surgery*
Found.—Foundation	*Surgs.—Surgeons*
Hosp.—Hospital	*S.—Surgical*

Note:—For items on societies not found in the Medical News Section, see alphabetical listing in Index.

Academie de Medicine (France), 65
Acad. of General Practice of Broward County (Fla.), 782
- of M. Sciences of the U. S. S. R., 404

Adams County (Ill.) M. Soc., 880
Aero M. A., 1245
Airlines M. Directors A., 1245
Alabama A. for Mental Health, 401
- M. A. of the State of, 1335

Alameda-Contra Costa (Calif.) Diabetes A., 1335
- (Calif.) M. A., 1335

Alaska Department of Health, 1150
- Hosp. Advisory Council, 490
- Territorial M. A., 491

Albany (N. Y.) Regional Health Conf., 217
Albert, Isaac, Research Inst., 217
Alpha Epsilon Delta, 1080
- Epsilon Iota (Syracuse Chapter), 983
- Kappa Kappa, 1241
- Kappa Kappa, Yale Chapter, 215
- Omega Alpha, 880
- Omega Alpha, Temple University Chapter, 1079

Alumni A. of Cornell University M. Coll., 1243
- A. of Jefferson M. Coll., 404
- A. of the St. Louis Coll. of Pharmacy and Allied Sciences, 302
- A. of the University of Oregon M. School, 1337

Societies and Other Organizations—*Continued*
Am. Acad. for Cerebral Palsy, 219
Acad. of Allergy, 305, 1152
Acad. of Dermatology and Syphilology, 786
Acad. of Forensic Sciences, 573
Acad. of General Practice, 65, 489, 490, 571, 683, 684, 686, 782, 880, 883, 903, 1118, 1523
Acad. of General Practice Chapters: Cleveland, 217; Dade County (Fla.), 880; Florida, 880; Massachusetts, 1419; Oregon, 1337; Utah, 1244; Virginia, 686; West Virginia, 1244
Acad. of Neurological Surg., 126, 786
Acad. of Neurology, 65, 1421
Acad. of Obstetrics and Gynecology, 66, 219, 686
Acad. of Occupational Med., 492
Acad. of Orthopaedic Surgs., 61, 219
Acad. of Pediatrics, 1339
Acad. of Pediatrics, Michigan Branch, 684
Acad. of Pediatrics, New Jersey Chapter, 1078
A. for the Advancement of Science, 65, 66, 784, 1420
A. for the Study of Liver Disease, 302
A. of Anatomists, 1151
A. of Blood Banks, 63, 305, 404
A. of Indust. Dentists, 1340
A. of Indust. Nurses, 1340
A. of Inhalation Therapists, 1525
A. of Pathologists and Bacteriologists, 1421
A. of Psychiatric Clinics for Children, 305
A. of Railway Surgs., 1245
A. of the History of Med., 1329
Board for Certification of the Prosthetic & Orthopedic Appliance Industry, Inc., 63
Board of Dermatology and Syphilology, 305
Board of Internal Med., 302, 488
Board of Neurological Surg., 62, 570
Board of Orthopedic Surg., 219
Board of Pathology, 301
Board of Preventive Med., 218, 1337
Board of Psychiatry and Neurology, 305
Cancer Soc., 302, 782, 786, 880, 882, 1339
Cancer Soc. Divs.: Arizona, 215; California, 786; Connecticut, 782; Illinois, 301, 783; Louisiana, 784; Montana, 881; New York State, 403
Chemical Soc., 218
Clinical and Climatological Soc., 302
Coll. of Allergists, 1340
Coll. of Chest Phys., 64, 683, 1246
Coll. of Chest Phys., Chapters: Alabama, 1335; Arizona, 1417; California, 1417; New Jersey, 684; New York State, 489; Ohio, 1243; Oklahoma, 1337; Texas, 1338; Wisconsin, 1338
Coll. of Gastroenterology, 61, 1245
Coll. of Phys., 572, 984, 985, 1340
Coll. of Radiology, 405, 1151, 1336, 1339
Coll. of Surgs., 62, 491, 687, 786, 882, 1341
Coll. of Surgs. Chapters: Metropolitan Chicago, 122; Michigan, 684; Tennessee, 1150; West Virginia, 1244
Coll. of Surgs., New Jersey Regional Trauma Comm., 570
Conf. of Governmental Indust. Hygienists, 1340
Cong. of Physical Med. and Rehabilitation, 491, 1245
Cong. of Physical Med. and Rehabilitation, Eastern Section, 1152
Cyanamid Company, Lederle Laboratories Div., 1523
Dermatological A., 304
Export Liners of New York City, 687
Federation for Clinical Research, 1420
Federation for Clinical Research Sections: Southern, 125; Western, 219, 1152;
Found. for Allergic Diseases, 1152
Gastroenterological A., 125, 1525
Golfer A., 1525
Group Psychotherapy A., 65
Hearing Soc., 215, 572
Heart A., 301, 304, 491, 1337, 1339
Heart A., Kansas Div., 684
Hosp. A., 406, 573
Hungarian M. A., 1243
Indust. Hygiene A., 65, 1340
Korean Found., 572
Laryngological, Rhinological and Otological Soc. Sections: Southern, 219; Western, 122
M. A., 65, 219, 1080
M. Golfing A., 1526
M. Soc. of Vienna, 126, 220, 305, 406, 572, 687, 787, 884, 985, 1081
M. Women's A., 61
Nuclear Soc., 305
Orthopsychiatric A., 883
Phys. Art A., 1080
Protestant Hosp. A., 406
Psychiatric A., 219, 786, 1526
Psychiatric A., New Jersey Dist. Branch, 1336
Psychoanalytic A., 1526
Psychological A., 882
Psychosomatic Soc., 985
AM.—*Continued*
Public Health A., 65, 401, 491
Public Welfare A., 1337
Radium Soc., 1245
Rheumatism A., 219
Rhinologic Soc., 783
Soc. for Artificial Internal Organs, 1339
Soc. for Clinical Investigation, 1525
Soc. for Surg. of the Hand, 218, 1152
Soc. for the Study of Arteriosclerosis, 126
Soc. of Clinical Pathologists, 1338
Soc. of Heating and Air-Conditioning Engineers, 216
Soc. of Maxillofacial Surgs., 405
Soc. of Otology, Rhinology and Laryngology, 63
Soc. of Tropical Med. and Hygiene, 124, 219, 1339
Trudeau Soc., 571
Urological A., 491
Anchorage (Alaska) M. Soc., 491
Andrew, John A., Clinical Soc., 1241
Arizona M. A., 1417
Soc. for Crippled Children and Adults, 215
Arkansas Acad. of General Practice, 1335
M. Soc., 1335
State Board of Health, 401
Armed Forces Inst. of Pathology, 65
Arthritis and Rheumatism Found., Illinois Chapter, 880, 1336
Associated Cardiac League, Inc., 1337
Glee Clubs of Greater New York, 881
A. for Research in Nervous and Mental Disease, 66
for Research in Ophthalmology, 687
for the Advancement of Psychoanalysis, 1079
of Allergists for Mycological Investigations, 305, 1340
of Am. M. Colls., 882
of Am. Phys. and Surgs., 1151
of Connecticut Tumor Clinics, 782
of M. Directors, 1151
of M. Illustrators, 126
of Protestant Hosp. Chaplains, 406
Atlanta (Ga.) Eye, Ear, Nose and Throat Soc., 782
(Ga.) Graduate M. Assembly, 568
Atomic Energy Comm., 65, 300, 302, 683
Austrian Soc. for Speech and Voice Therapy, 124
Baltimore City M. Soc., 125, 1524
Barbour-Randolph-Tucker (W. Va.) M. Soc., 1150
Bayshore Exchange Club of Miami Beach (Fla.), 301
Beaumont Memorial Comm., 62
Bergen Community Blood Bank (N. J.), 781
Bio-Chemical Research Found., 65
Blackwell Soc., 216
Bronx County (N. Y.) M. Soc., 1419
Soc. of Neurology and Psychiatry, 217, 983
Brooklyn (N. Y.), Acad. of General Practitioners of, 1419
(N. Y.), Acad. of Med. of, 123, 489, 983, 1336
(N. Y.) Cancer Comm., 1419
(N. Y.) Symphony Orchestra, 217
(N. Y.) Eye and Ear Hosp. Alumni A., 1149
Broome County (N. Y.) M. Soc., 1149
Buffalo Acad. of Med., 685
Consistory, 784
S. Soc., 784
Bunts, Frank E., Educational Inst., 217, 882
Burroughs Wellcome and Company, 405
California A. of Clinical Laboratories, 215
Blood Bank System, 568
M. A., 1417
Office of Civil Defense, 401
Southern Dental and Pharm. A. of, 61
Speech Therapy A., 61
Callaghan and Company, 404
Canada, Western, S. Soc. of, 1341
Canadian A. of Physical Med. and Rehabilitation, 220
Cancer Soc. for Phys. (Conn.), 782
Cytology Found. of America, Inc., 125
Caspary, Alfred H. and Margaret M., Found., 303
Catholic Hosp. A., 1339
Central Soc. for Clinical Research, 302
S. A., 572
Chesapeake & Ohio Railway, 686
Chesley Memorial Fund Comm., 569
Chicago Diabetes A., 881, 783
Funeral Directors' A., 881
Health Department, 982
Heart A., 62, 122, 216, 301, 402, 881
Inst. of Med. of, 783, 1336
M. Directors Club of, 123
M. Soc., 62, 569
Neurological Soc., 1241, 1523
Ophthalmological Soc., 402, 982
Orthopaedic Soc., 122, 783, 1241
Park Dist., 62
Pathological Soc., 881
Police Department, 62
Roentgen Soc., 405
Soc. of Internal Med., 1418
Soc. of M. History of, 122, 783
CHICAGO—*Continued*
Soc. of Physical Med. and Rehabilitation, 62, 683, 881, 1336
Tuberculosis Soc., 881
Cincinnati, Acad. of Med. of, 984, 1149
Heart Council, 1149
Soc. of Neurology and Psychiatry, 124, 490, 984
Civil Aeronautics Administration, 1245
Aviation M. A., 1244, 1245
Cleveland Clinic Found., 217, 882
Dental Soc., 882
Coll. of Am. Pathologists, 1151, 1245
of Am. Pathologists Regions: North Central, 305; Northwestern, 1525
Colorado Otolaryngological Soc., 188
Radiological Soc., 300
State M. Soc., 401
Columbus (Ohio) Civil Service Comm., 1337
Commissioner's Conf. (Mich.), 402
Comm. on Internat. Exchange of Persons, 491
Commonwealth Fund, 783, 1079
Community Health A., 61
Conf. Board of Associated Research Councils, 491
of State and Provincial Public Health Laboratory Directors, 1151
on Physical Med. and Rehabilitation (Chicago), 62
Connecticut Allergy Soc., 402, 1418
Hosp. A., 215
M. Examining Board, 215
M. Service, 1241
Soc. of Pathologists, 1418
State Department of Health, 782
State M. Soc., 61, 215, 782, 1417
State Soc. of Anesthesiologists, 1417
Constantinian Soc., 1244
Coordinating Council for Cerebral Palsy, 570
Cosmopolitan Club (Virginia), 686
Council of Am. Bioanalysts, Western Section, 215
of State Governments, 1080
County M. Soc. Officers' Conf. (Ky.), 1078
Soc. Officers Conf. (Indiana), 982
Cuban Soc. of Gastroenterology, 568
Dallas (Texas) Southern Clinical Soc., 882
Delaware Acad. of General Practice, 683
Delta Epsilon, Chi Chapter, 303
District of Columbia, M. Soc. of the, 488
Doctors' Chorus (N. J.), 881
DuPage County (Ill.) M. Soc., 122
Easter Seal Research Found., 786
Eastern Conf. of Radiologists, 125
Psychiatric Research A., 786
Educational Fund of Mount Sinai Hosp. of Greater Miami (Fla.), 880
Egypt, Ophthalmological Soc. of, 573
Egyptian Ministry of Health, 124
Erie County (N. Y.) M. Soc., 403
Evansville (Ind.) Epilepsy League, 684
Fayette County (Iowa) M. Soc., 489
County (W. Va.) M. Soc., 1150
Federal Bureau of Investigation, 215
Civil Defense Administration, 1151
Fidelity Mutual Life Insurance Company, 490
Fifty Year Club (Montana) M. A.'s, 684
Florida Citrus Comm., 985
Forsyth County (N. C.) M. Soc., 984
Franklin Inst., 65
Friedenwald Memorial Fund, 687
Gastroenterology Research Group, 1421
General Motors Corporation, 569
Genesee County (Mich.) M. Soc., 1242
Georgia Heart A., 880
Soc. of Ophthalmology and Otolaryngology, 782
State Health Department, 880
German M. Soc. of Chicago, 1078
Governor's Comm. on Handicapped Children, 983
Greene County (Mo.) M. Soc., 1419
Harrisburg (Pa.) Acad. of Med., 404
Hartford (Conn.) M. Soc., 122, 300
County (Conn.) M. A., 122
John A., Found., 216
Hawaii, Am. Coll. of Phys. of, 984
M. A., 786
Hawaiian Soc. of Anesthesiologists, 786
Hektoen Inst. for M. Research, 568
Henry Ford Hosp. M. Soc., 881
Honolulu Pediatric Soc., 304
Houston (Texas) Heart A., 218
(Texas) Neurological Soc., 882
Illinois Acad. of General Practice, 402, 1523
Public Health A., 1148
State Department of Public Health, 982
State Department of Welfare, 683
State M. Soc., 301, 1078
Indian Council on M. Research, 300
M. A., 884
Ministry for Health, 303
Indiana Cancer Soc., 1078
State M. A., 982
Indianapolis M. Soc., 1242
Indust. Health Conf., 1340
M. A., 1340
Ingham County (Mich.) M. Soc., 1524

Societies and Other Organizations—Continued
Inst. for the Crippled and Disabled, 403, 883
of Biology and Experimental Med. (Argentina), 687
of Pathology (University of Tennessee), 125
of Physiology (Argentina), 687
Internat. Acad. of Pathology, 1421
Acad. of Proctology, 1421
Anesthesia Research Soc., 1244
A. of Allergology, 683
A. of M. Museums, 1421
Children's Center (France), 883
Coll. of Surgs., 405, 572, 889, 1122
Coll. of Surgs., Div.: Great Lakes, 1420; Indiana, 982; Northern California Chapter, Southern Div. of the, 985
Coll. of Surgs., United States Section, 406, 1525
Conf. on the Peaceful Uses of Atomic Energy, 66
Cong. of M. Radiophotography, 883
Cong. of Otolaryngology, 125
Cong. of Physical Med., 491
Cong. on Diseases of the Chest, 1246
Exposition of Sanitary Arts, 1081
Federation of Physical Med., 786
Fertility A., 66, 786
French-Speaking Anatomicopathologists' Cong., 1341
Hosp. Federation, 406
M. and Scientific-Film Exposition, 1081
M.-S. Meetings, 1081
Physiological Cong., 785
Soc. for Orthopaedic Surg. and Traumatology, 219
Soc. of Geographic Pathology, 125
Symposium on the Diencephalon, 1245
Union for Health Education of the Public, 1422
Inter-Soc. Cytology Council, 786
Interstate Orthopedic Soc., 1339
Invitational Scientific Cong. (Am. Acad. of General Practice), 880
Iowa Acad. of General Practice, 489
State M. Soc., 1418
Italian Soc. of Experimental Biology, Milan Section, 1246
Soc. of Neurology, 687
Soc. of Rheumatology, 66
Jackson County (Mich.) Cancer Soc., 1419
County (Mich.) M. Soc., 1419
County (Mo.) M. Soc., 1078
Jacobson-Elsner M. Soc. (Syracuse, N. Y.), 302
Jewish Peoples Inst., 982
Just One Break Comm., 403
Kansas City (Kan.) Heart A., 684
City Soc. of Ophthalmology and Otolaryngology, 882
M. Soc., 1523
Public Health A., 1242
Soc. of Pathologists, 1151
State Board of Health, 681, 1242
Karolinska Institutet, 61
Kentucky State Health Department, 793
State M. A., 489, 1078
Kimble Glass Company, 1151
King County (Wash.) M. Soc., 785
Kings, County of (N. Y.), M. Soc. of the, 123, 217, 489, 883, 1336, 1419, 1524
Kotaes, Richard, Memorial Fellowship Fund, 491
Lanpar Company, 880
Laurentian Hormone Conf., 1420
League Against Trachoma, 1341
Lee County (Ala.) Mental Health A., 300
Levy, J. J., Memorial Fund, 302
Life and Casualty Insurance Company, 124
Lilly, Eli, & Company, 1339
London, M. Soc. of, 63
Long Island (N. Y.) Hearing and Speech Soc., 1079
(N. Y.) Indust. Nurses A., 1079
Los Angeles County Health Department, 401
County M. A., 61, 401, 782
County Office of Civil Defense, 401
Metropolitan Dermatological Soc. of, 488
Radiological Soc., 122
Louisiana State M. Soc., 1419
Mackie, Thomas T., Fund, 303
Maine Department of Health and Welfare, 983
Soc. of Anesthesiologists, 302
Trudeau Soc., 983
Marion County (Ind.) Cancer Soc., 1242
Maryland Acad. of General Practice, 402
M. and Chirurgical Faculty of the State of, 1523
Massachusetts School Phys.' A., 1148
Trudeau Soc., 571
Tuberculosis and Health League, 571
Mecklenburg County (N. C.) M. Soc., 573
M. A. of the Lutheran Hosp. of Maryland, 1419
Library A., Midwest Regional Group, 304
Medicinhies of Minnesota, 782
Merrell, Wm. S., Company, 64
Metropolitan Life Insurance Company, 122, 572
Miami (Fla.) Greater Heart A. of, 883
(Fla.) Greater, Radiological Soc., 568
(Fla.) Heart Inst., 782
Michigan Acad. of General Practice, 1148
Cancer Coordinating Comm., 684
Crippled Children Comm., 569
Department of Health, 569
Found. for M. and Health Education, 681
Heart A., 681
Pathological Soc., 405
Soc. for Mental Health, 881
State Board of Alcoholism, 781
State M. Soc., 62, 216, 569
Microcirculatory Conf. for Physiology and Pathology, 1151
Mid-South Postgraduate M. Assembly, 491
Milwaukee County (Wis.), M. Soc. of, 401, 786, 981
Junior Chamber of Commerce, 984
Mississippi Valley M. Soc., 65, 125
Missouri Health Council, 302
Soc. of Anesthesiologists, 684
Soc. of Pathologists, 1151
State M. A., 1148, 1149
Montana Acad. of Oto-Ophthalmology, 681
M. A., 881
Radiological Soc., 684
Trudeau Soc., 1419
Muscular Dystrophy A. of America, Inc., 301, 684
Mutual Benefit Health and Accident A. of Omaha, 491
Nalle Clinic Found., 1337
Nassau County (N. Y.) Tuberculosis and Public Health A. Indust. Health Div., 1079
(N. Y.) Neuropsychiatric Soc., 983
Nat. Acad. of Sciences, 66
A. for Mental Health, 124, 786, 1339
A. of Methodist Hosps. and Homes, 406
Conf. of Christians and Jews, 305
Cong. of Pediatrics of Mexico, 1245
Council to Combat Blindness, 1080
Found. for Infantile Paralysis, 219, 491
Fund for M. Education, 62
Heart Inst., 217
Inst. for Neurological Diseases and Blindness, 982
Inst. of Cardiology, 1421
Inst. of Mental Health, 401
Inst. of Neurological Diseases and Blindness, 301, 1337
Insts. of Health, 301, 883
M. A., 61
Nephrosis Found., 215
Office of Vital Statistics, 122
Research Council, 66
Soc. for Crippled Children and Adults, 124, 786
Soc. for the Prevention of Blindness, 982, 1080
Vitamin Found., 302, 304, 687
Naugatuck (Conn.) Valley M. Soc. of the lower, 301
Nebraska Acad. of Ophthalmology and Otolaryngology, 882
Heart A., 301
State M. A., 216
Nevada State M. A., 403
New England Conf. on Human Nutrition, 985
Roentgen Ray Soc., 123
Soc. of Anesthesiologists, 304, 687, 1525
New Jersey, Acad. of Med. of, 570, 1079
Central, Pediatric Soc. of, 1078
Diabetes A., 881
Heart A., 570
M. Soc. of the State of, 1078
Neuropsychiatric A., 403, 1336
Orthopaedic Soc., 570
Rheumatism A., 685
Soc. of Surgs. of, 881
State Department of Health, 1078
New Mexico M. Soc., 1524
New Orleans Graduate M. Assembly, 302
New York Acad. of Gastroenterology, 63
Acad. of Med., 63, 123, 303, 490, 570, 682, 1079, 1337, 1419
Acad. of Sciences, 785, 1149
Allergy Soc., 123
Cancer Soc., 403, 785, 1079
City, Welfare and Health Council of, 1337
County M. Soc., 1243
Doctors' Orchestral Soc., 570
Inst. of Clinical Oral Pathology, 570, 1524
M. Soc. of the State of, 1149
Roentgen Ray Soc., 125
Roentgen Soc., 570, 984
Soc. for Clinical Ophthalmology, 1242, 1243
State Charities Aid A., 303
State Department of Agriculture, 124
State Department of Health, 63, 685, 784
State Department of Mental Hygiene, 685
State Div. of Vocational Rehabilitation, 403
State Employment Service, 403
State Hosp. A. of, 685
State Psychiatric Inst., 63, 685, 785
State Public Health Council, 123
State Soc. of Indust. Med. Inc., 302
Tuberculosis and Health A., 1149
North Carolina, M. Soc. of the State of, 1420
State Board of Health, 1420
Northeast State Governments Conf. on Mental Health, 1080
Northern Tri-State M. A., 1245
North Pacific Soc. of Neurology and Psychiatry, 1245
Northwest Soc. for Clinical Research, 219
Nu Sigma Nu, 783
Nu Sigma Nu, Albany M. Coll. Chapter, 983
Nutrition Conf. (Detroit), 1242
Oak Ridge (Tenn.) Inst. of Nuclear Studies, 65
Occupational Center of Essex County, Inc. (N. J.), 402
Ocean (N. Y.) M. Soc., 982
Ohio Department of Mental Hygiene and Correction, 190, 1150
State M. A., 1243
Oklahoma Acad of General Practice, 401, 1079
County M. A., 1337
State M. A., 404
Omaha and Council Bluffs (Iowa) Ophthalmological and Otolaryngological Soc., 882
Mid-West Clinical Soc., 123
Onondaga County (N. Y.) M. Soc., 685, 1243
Optical Soc. of America, 65
Order of the Sons of Italy in America, 218
Oregon Radiological Soc., 1337
Pacific Coast Oto-Ophthalmological Soc., 1340
Northwest Soc. of Pathologists, 1525
Pan Am. Cancer Cytology Cong., 125
Cong. of Gastroenterology, 126, 568
Cong. of Otorhinolaryngology and Bronchoesophagology, 787
Cong. on Gerontology, 220
Sanitary Bureau, 63, 1421
Parke, Davis & Company, 62
Pennsylvania, Commonwealth of, Department of Health, 63
Conf. of Tuberculosis Workers, 1420
Department of Health, 124
M. Soc. of the State of, 124, 882
Southeastern, Heart A. of, 65
Trudeau Soc., 1420
Tuberculosis and Health Soc., 490, 1420
Phi Beta Pi, 403
Delta Epsilon, 126, 1079, 1243
Delta Epsilon Chapters: Alpha Eta, 1335; Alpha Lambda, 1420; Alpha Mu, 1150; Alpha Omicron, 784; Alpha Pi, 1419; Alpha Theta, 1336; Beta Zeta, 882; Omega, 1242; Zeta, 1242
Delta Epsilon Found., 1241, 1523
Epsilon Pi, 489
Lambda Kappa, 783, 1080
Philadelphia, Coll. of Phys. of, 63
County M. Soc., 1243
Department of Public Health, 1080
Roentgen Ray Soc., 125
Pilot Club (Abbeville, S. C.), 571
Pittsburgh Tuberculosis League of, 124
Planned Parenthood A. (Tokyo, Japan), 786
Polk County (Iowa) M. Soc., 123
Population Reference Bureau, 63
President's Comm. on Employment of the Physically Handicapped, 783
Press-Radio-TV Conf. (W. Va.), 61
Preston County (W. Va.) M. Soc., 786
Public Health Found. for Cancer and Blood Pressure Research Inc., 125
Pulaski County (Ark.) M. Soc., 1335
Queens, County of (N. Y.), M. Soc. of the, 983
Radiological Soc. of North America, 219
Raleigh (N. C.) Acad. of Med., 685
Ramsey County (Minn.) M. Soc., 983
Research Study Club of Los Angeles, 122
Rhode Island M. Soc., 1524
Richmond (Va.) Acad. of General Practice, 1244
Ridgeboro (N. Y.) M. Soc., 1524
Rockaway (N. Y.) M. Soc., 1336
Rockefeller Found., 300
Roman Rheumatological Days, 66
Rosenthal, Richard and Hinda, Found., 784
Royal Australasian Coll. of Surgs., 303
Sanitary Inst., 985
Soc. of Edinburgh, 687
Soc. of Health, 985
Rural Health Conf. (S. D.), 1079
Sage, Russell, Found., 1337
St. Louis City Hosp. Alumni A., 1148
M. Soc., 302
St. Petersburg (Fla.) Heart A., 568
Salt Lake County (Utah) M. Soc., 218
San Jose (Calif.) S. Soc., 488
Scott County (Iowa) M. Soc., 983
Scripps Found. for Research in Population Problems, 65
Seattle S. Soc., 218
Sioux Valley (Iowa) M. A., 569
Sloan Inst. of Hosp. Administration, 881
Smithsonian Institution, 215
Sociedad Cubana de Gastroenterologia, 126
Interamericana de Gastroenterologia, 126
Societe Francaise d'Ophthalmologie, 1341
Soc. of Am. Bacteriologists, 1525
of Biological Psychiatry, 1421
of Internists and of Fellows of the Nat. Inst. of Cardiology, 1421
of M. Consultants to the Armed Forces, 64
of M. Psychoanalysts of New York, 785
of Nuclear Med., 304
of University Surgs., 405

Societies and Other Organizations—Continued
South Atlantic A. of Obstetricians and Gynecologists, 220, 1152
South Carolina Pediatric Soc., 571
Soc. of Anesthesiologists, 571
S. Soc., 571
Trudeau Soc., 685
South Dakota Health Advisory Council, 304
Soc. of Internal Med., 304
State Department of Health, 304, 1079
State M. A., 1079
Southeastern S. Cong., 883
Southern Baptist A. of Hosp. Chaplains, 406
M. A., 126
Neurosurgical Soc., 985
Soc. of Cancer Cytology, 66, 125
Thoracic S. A., 66, 304
Southwest Blood Banks, Inc., 300
Southwestern S. Cong., 1340
Spokane (Wash.) S. Soc., 1150
Stamford (Conn.) Heart A., 1148
States' M. Postgraduate A., 401
Statewide Conf. on Handicapped Children (La.), 883
Steinberg Charitable Trust, 123
Subspecialty Board of Allergy, 488
Sunshine League for Retarded Children, Rochester (N. Y.) Chapter, 570
Syracuse (N. Y.) Acad. of Med., 685
Tacoma (Wash.) S. Club, 1524
Tarrant County (Texas) M. Soc., 686
Tennessee Acad. of General Practice, 1150
Diabetes A., 1150
Heart A., 1150
Radiological Soc., 1150
Soc. of Pathologists, 1150
State M. A., 686, 1149
State Pediatric Soc., 1150
Texas, East, Area Council of Boy Scouts of America, 1338
M. A., 1338
State Department of Health, 218
Urological Soc., 686
Third Dist. (S. C.) M. Soc., 685
Thirteenth Dist. (Texas) M. Soc., 1150
Tissue Culture A., 1151
Tobacco Industry Research Comm., 572
Tommy Memorial Fund, 122
Tri-State M. A., 573
Tuberculosis Inst. of Chicago and Cook County, 880
Tucson (Ariz.) M. Center Auxiliary, 300
Tufts M. Alumni A., 1242
Tulsa (Okla.) Acad. of General Practice, 217, 1079, 1420
County (Okla.) M. Soc., 61
Tuskegee Inst., 1241
Twin City (Minn.) Urologic Soc., 889
United Cerebral Palsy A. of San Francisco, 401
Nations, 66
Nations Children's Fund, 883
U. S. Army, 782
Department of Health, Education, and Welfare, 985, 1080
Mexico Border Public Health A., 1245
Office of Vocational Rehabilitation, 217, 403
Post Office Department, 1339
Public Health Service, 66, 122, 125, 300, 401, 571, 687, 782, 783, 1078
State Department, 884
United States Steel Corporation, 122
Utah State Department of Health, 686
State Soc. of Anesthesiologists, 218
Trudeau Soc., 686
Vanderburgh County (Ind.) M. Soc., 783
Vermont Alcoholic Rehabilitation Comm., 571
Bar A., 1080
Department of Health, 1080
State Department of Education, 1338
Tuberculosis and Health A., 571
Veterans Administration, 882, 1339
Viennese Psychoanalytic Soc., 63
Virginia League for Planned Parenthood, 1244
Northern, Acad. of Surg., 1338
Obstetrical and Gynecological Soc., 686
Soc. of Pathology and Laboratory Med., 984
Washington Psychoanalytic Inst., 403
State Obstetrical A., 1150
Washtenaw County (Mich.) M. Soc., 1245
Wayne County (Mich.) M. Soc., 62, 402, 784
Western A. of Phys., 1152
Conf. of Catholic Hosps., 1339
Gerontological Soc., 1339
Indust. M. A., 1421
Soc. for Clinical Research, 219, 1152
West Virginia Pediatric Soc., 984
State Bar, 1150
State M. A., 64, 786, 1150
Whitfield-Murray (Ga.) Health Department, 782
Williams & Wilkins Company, 64
Found. (Buenos Aires, Argentina), 125
Wills Eye Hosp. Ex-Resident Soc., 490
Wisconsin Acad. of General Practice, 1525
Anti-Tuberculosis A., 1338
Radiological Soc., 218
Soc. of Internal Med., 572
Wisconsin—Continued
State Department of Public Instruction, 490, 686, 1150
State M. Soc. of, 301, 1525
Wohl Found., 880
Woman's Auxiliaries: Arizona M. A., 1417; Baltimore City M. Soc., 1524; Connecticut State M. Soc., 1418; Louisiana State M. Soc., 1419; Maryland, M. and Chirurgical Faculty of the State of, 1524; North Carolina, M. Soc. of the State of, 1420; Onondaga County (N. Y.) M. Soc., 1243; Pennsylvania, M. Soc. of the State of, 882; Texas M. A., 1338
World Cong. on Fertility and Sterility, 66
Health Organization, 124, 883, 1151, 1421
Wyoming State M. Soc., 572
Yale M. Soc., 488, 1241

T

TEM: See Triethylene Melamine
TSH: See Thyrotropin
T-TUBE
drainage with sphincterotomy for postcholecystectomy dyskinesia, [Walters] *425
TABES DORSALIS
incidence after early treatment of syphilis, Switzerland, 995
TACHYCARDIA
neurocirculatory asthenia with, drugs or exercise for? 726
TAKAYASU'S SYNDROME
pulseless disease, [Boccardelli] 1261—ab
TAMPONADE
cardiac (acute), after sternal marrow aspiration, [Jenkins] 326—ab
intragastric balloon for bleeding esophageal varices, [Linton & Ellis] *1017
TAPEWORM INFECTION: See Dipylidium; Taeniasis
TAX
income (federal), deduction of postgraduate course expenses [Medicine and the Law] *399
income (federal) deductions for voluntary pensions, Jenkins-Keogh bills explained, [Keogh] 1234
sales, increases to increase N.H.S. cost, United Kingdom, 798
TEACHERS
epileptic, employment conditions, England, 74
TEBAFEN
treatment of tuberculosis, Ireland, 1253
TEETH
caries, British Dental Ass'n. denies that dentifrices will prevent, 315; 702
caries, nutrition related to, Italy, 133
extraction, antibiotics for gingival sulcus to prevent bacteremia, [Bender] 886—ab
TELEPHONE
amplifier, portable, [Hosmer] *285
answering services, [Public Relations] 1416
dial "DOC" for emergency proposed, United Kingdom, 502
TELEVISION
Academy of Medicine of Cincinnati series, 984
A.M.A. Chicago Meeting color program, 1505
A.M.A. films for the public, [Public Relations] *520
A.M.A. forms Physician's Advisory Committee, 1147; 1322
British Medical Ass'n. examines physician anonymity, 1531
"March of Medicine" programs, 1147
"Medic," Michigan honors Los Angeles County Ass'n for, (photo) 121
mental health legislative session televised, W. Va., 785
mental health program, March 18, 786
"Navy Log" filmed physical therapy service of naval hospital, 888
physician and medical societies relation to, [PRoblem Corner] *60
postgraduate medical education by, [Warner & Bowers] *1306
TEMPOROMANDIBULAR JOINT: See Jaws
TENDONS
calcifying peritendonitis, Brazil, 313
overstretched, popping joints probably from recoil of, 424
TENIASIS
treatment, quinacrine, 518
TENSILON: See Edrophonium
TERMINOLOGY: See also "Words and Phrases" under Medicolegal Abstracts at end of letter M
Dr. E. T. Thompson, editor of STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS, 1147; 1322
regional Standard Nomenclature Institutes, Atlantic City, Feb., 1956, 296
TERRAMYCIN: See Oxytetracycline
TESTES
cancer (metastatic), chemotherapy, [Wildermuth] 146—ab
excision and/or cortisone with transurethral resection for prostate cancer, [Pool & Thompson] *833
TESTES—Continued
excision in prostate cancer, [Ganem] 916—ab
Hormone: See Androgens
in etiology of infertility, [Tyler & Singher] *91
undescended, surgery for, [Gross & Jewett] *634
TESTIMONY
medical, physician-attorney relationship, [Medicine and the Law] *1413
medicolegal, A.M.A. surveys of committees for review of, [Medicine and the Law] *1334
TESTOSTERONE: See Androgens
TETANUS
antitoxin level after toxoid; booster dose effects, [Looney] 907—ab
diphtheria and, toxoids; potency and dosage control [Greenberg & Benoit] *108
fever reaction after triple vaccine, 1004
immunization, toxoid vs. antitoxin; alum precipitated vs. fluid toxoids, (reply) [Edsall] 1186
severest, curarization with tracheotomy and artificial respiration for, [Mollaret] 80—ab
treatment, chlorpromazine, [Cole] 321—ab; (United Kingdom) 1352
vaccination for children for Asiatic travel, 817
TETANY
aminoaciduria in children with, France, 1350
etiology; ovarian dysfunction, [Sandock] *659
TETRACAINE
in anterior stellate block, [Moore & Bridenbaugh] *158
vs. hexylcaine for endoscopy, [Orkin & Rovenstine] *1465
TETRACYCLINE
Ministry of Health's notes on economics of prescribing, England, 314
treatment of bronchopneumonia in infants, Austria, 1426
treatment of fistulating bone tuberculosis with mixed infection, [Behrendt] 79—ab
treatment of surgical infections, [Pulaski] 1092—ab
TETRACYN: See Tetracycline
TETRAETHYLAMMONIUM CHLORIDE
treatment of porphyria in pregnancy, [Durst & Krembs] *165
TETRAMETHYLTHIURAM DISULFIDE
in antiseptic soap, allergy to, [Blank] *1225
TETRAPLEGIA
traumatic, exoskeletal splithook prostheses for, in arms, [Nyquist] *761
TETRYL (Trinitrophenylmethylnitramine)
propellant vs. detonator, [Schaefer] 586—C
TEXAS
Harris County plan of mobile support for civil defense, [Olson & others] *1202; [Howard & others] *1211
TEXTILES: See also Nylon; Orlon
dermatitis from, especially industrial, [Braitman] 421—ab
woven synthetic prostheses in vascular system, [Deterling] 807—ab
THEORELL, NILS HUGO, Nobel prize winner in physiology and medicine, Sweden, 134
THERAPEUTICS
deaths caused by, United Kingdom, 1353
duplication in chronic disease, 780—E
overtreatment dermatitis [Gaul] 1001—ab
unverifiable hypothesis: what would have happened if therapy differed? 563—E
what mothers prescribe, England, 73
THIAMINE
pyrophosphate for diabetic coma, [van Marken Lichtenbelt] 333—ab
THIOPENTAL SODIUM
nitrous oxide with, for minor surgical procedures? 518
oxygen-nitrous oxide anesthesia, (levallorphan and alphaprodine with) [Foldes & others] *168; (meperidine, with) [Ausherman & others] *175
THIOURACIL
treatment of hyperthyroidism in childhood, [Van Wyk] 1536—ab
THOMPSON, EDWARD T., editor of STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS, 1147; 1322
THOMS-WILSON TECHNIC
for pelvimetry using single x-ray film, [Thoms & Billings] *148
THORACIC DUCT
tumor emboli in, in pathogenesis of Virchow's node, [Zeidman] 721—ab
THORAX
auscultation to diagnose lung cavitation, [Guillaudeu] 1258—C
chest disease in agammaglobulinemia, [Good] 710—ab
chest pain relieved by drinking water and eructation, diagnosis? 1099
chest x-rays in intestinal lipodystrophy, [Eyler & Doub] *534
chest x-rays, surveys, (Sweden) 134; (value; reply to Dr. Garland) [Zahn & others] 317—C; (value, United Kingdom) 1429

THORAX—Continued
emphysema after fracture of facial skeleton, [Hedup] 240—ab
International Congress on Diseases of the Chest, Germany, Aug., 1246
surgery, thoracotomy; cardiac irregularities effect on auricular hemodynamics, [Wilson] 1263—ab
surgery, thoracotomy for surgical cardiac arrest, [Briggs & others] *1439
surgical wound healing with or without dressings, [Palumbo & others] *553
THORAZINE: See Chlorpromazine
THORIUM
late follow-up on internal deposition, [Looney & Cebadrin] *1
THROAT
bacteria during chemoprophylaxis of rheumatic fever, [Miller] 1261—ab
exudates, benzathine penicillin G for carriers of streptococci, [Brooks & Moe] *162
sore, recurrent in winter, with fever; treatment, 151
THROMBOCYTOPENIA: See Purpura, thrombocytopenic
THROMBOEMBOLISM: See Thrombosis
THROMBOPHLEBITIS
in genitourinary surgery, [Mathé] 917—ab
of pregnancy, France, 1250
superficial, phenylbutazone for, [Stein] 85—ab
treatment, [Olwin] *1101
THROMBOPLASTIN
formation, erythrocyte factor relation to, [de Vries] 337—ab
THROMBOSIS
coronary, questionnaire on Eisenhower running for second term, A.M.A. opposes answering, 52—E
in atheroma etiology, United Kingdom, 585; [Levene] 721—ab
of basilar artery from neck manipulation, [Ford] 1264—ab
of hepatic vein indicated by vena caval occlusion with enlarged liver and acidosis, (reply) [Jacobson] 1100
of longitudinal sinus in infants, [Bustamante] 718—ab
treatment, [Olwin] *1101
treatment, Fibrus officinalis, [Augusto] 333—ab
THYMECTOMY
states in myasthenia gravis, [Eaton] 141—ab
THYMUS
neoplasms, [Effler] 805—ab
tumor with blood dyscrasias, (Diagnostic Problems) [Ramos] *1317; (comment) [Loeb] *1319
THYROID
aberrant lateral, [Bloch-Michel] 595—ab
aberrant, tumors in, [Sabbatini] 903—ab
cancer, papillary; danger of surgical spread, [Crile] 1263—ab
cancer, papillary; life-expectancy; neck dissection for? 89; (replies) [Duffy; Wuester; Lichtenstein] 1269; [Winship; Crile] 1270
cancer, papillary; pathology, [Frazell] 711—ab
cancer, surgical results, [Shallow] 1263—ab
cancer with lung metastases, [Catz & Starr] *1046
desiccated, vs. triiodothyronine for myxedema, [Frawley & others] *646
disease with exophthalmos, visual defects in, [Hedges] 604—ab
hormone for primary myxedema from postpartum shock, United Kingdom, 502
neurothyroid concept of Basedow's disease, [Klotz] 157—ab
struma lymphomatosa, serum colloidal gold test in diagnosis, [Skirpan] 334—ab
Triac, thyromimetic drug, United Kingdom, 1532
tumors, adenoma genesis of in siblings, [Zondek] 1260—ab
tumors, Hürthle cell, India, 696
tumors, malignant; conservative surgery for, [Crile] 140—ab
THYROIDECTOMY
indications for, 920
keloids after, no effective treatment in younger people, 248
subtotal, amount of tissue to preserve, [Szilagyi] 139—ab
vulnerability of recurrent laryngeal nerves at, [Wade] 713—ab
THYROIDITIS
subacute, cortisone for, [Hoyne] 710—ab
THYROXINE: See Tribromothyronine; Triiodothyronine
THYROTOXICOSIS: See Goiter, Toxic
THYROTROPIN (TSH; Thyrotropic Hormone)
to stimulate I^{131} collection by metastatic thyroid cancer, [Catz & Starr] *1046
THYROXIN
like activity of tribromothyronine in experimental goiter, United Kingdom, 996
sodium, vs. triiodothyronine for myxedema, [Frawley & others] *646
TIC Douloureux: See Neuralgia, trigeminal
TIES
ready-made bow-ties, multipurpose clip from, [Hyman] 76—C
TIETZE'S DISEASE
surgical treatment, [Nix] 241—ab
treatment, hydrocortisone, [Celio] 241—ab
TINEA
capitis, Wood's glass to detect in adolescence, 424
TINNITUS
aurium, heparin for, Austria, 794
aurium with no apparent cause, treatment, 1208
TISSUES
damage, blood aminopherase in, [Merrill & others] *1454
destroying process, C-Reactive protein test for, 674—E
preservation and amputations, refrigeration for, [Crossman] 1002—ab
tissue committee in hospital accreditation, [Medicine and the Law] *1238
TISSUES (paper)
facial, with urea-formaldehyde resin, allergy to, [Peck & Palitz] *1226
TOBACCO
ball-bearocardiographic cigarette test, [Davis] 1094—ab
consumption, Denmark, 580
eye damage by, [Hedges] 604—ab
in etiology of larynx cancer, [Wynder & others] *1384
in etiology of lung cancer, United Kingdom, 1430
research fund enlarged, 572
smoking adversely affects neurological diseases, United Kingdom, 585
waterpipe smoking and lung cancer, 248
TOES
second, nontraumatic dislocation in older obese women, (reply) [DuVries] 728
TOILET FACILITIES
deodorization of, 1184
TOLSERAM: See Mephenesin carbamate
TOLSEROL: See Mephenesin
TOLULEXIN: See Mephenesin
TOMATO JUICE
vitamin C standards, (Council report) *1471
TONGUE
coated, clinical value, United Kingdom, 1353
glossoptosis and micrognathia, [Jaso] 811—ab
TONOMETRY
evaluation of Berens-Tolman indicator, [Chobet & Horovitz] *661
TONSILLECTOMY
inflammatory rheumatism and, France, 1163
vitamins K and C to prevent bleeding after, [Harkins] 1536—ab
TONSILS
cancer, France, 581
TOOTHPASTES: See Dentifrices
TORTICOLLIS
acquired, in children and young adults, [Donaldson] *458
after pharyngitis, Austria, 794
toxazolamine as muscle relaxant in, [Amols] *742; [Smith & others] *745
TOXICOSIS: See Dehydration
TOXOPLASMOSIS
congenital, diagnosis, [Morris] 682—ab
TRACHEA
Iiptodol injected into, for bronchography safe? 88
tumors, granuloma after intratracheal anesthesia, (reply) [Lurie] 90
TRACHEOSTOMY
uncuffed tube for artificial respiration, [Mörch & others] *804
TRACHEOTOMY
curarization and artificial respiration with, for severe tetanus, [Mollaret] 88—ab
surgical technic and safeguards, [Georgiade & others] *940
TRACTION
in children with fractured femurs, [Stryker] *288
lumbar, eliminate factors preventing stretch, (reply) [Bodovich] 1256—C
skin, legging for, [Anderson & Robbins] *1315
TRADE: See Industrial
TRAFFIC Accidents: See Automobiles
TRANSAMINASE (aminopherase)
in blood, clinical experiences, [Merrill & others] *1454
in blood in hepatitis, [Wróblewski & LaDue] *1130
in blood to diagnose myocardial infarction, [Kattus & others] *16; [Goldner] 594—ab
TRANSILLUMINATOR
for retinal detachment and surgery, [Berens] 159:1532, Dec. 17, 1955; (correction) 160:192, Feb. 11, 1956
TRAUMA
Army symposium in Honolulu, 989
boating injuries, United Kingdom, 798
cerebrospinal rhinorrhea after face injury, when to do submucous resection, 151
effect of blood loss and transfusion on water, electrolyte and nitrogen metabolism after, [Fleur] 419—ab
fat embolism of retina after, [Kearns] 1370—ab
TRAUMA—Continued
hazard in cryptorchism justifies surgery, [Gross & Jewett] *634
in etiology of cancer, 342
in etiology of conditions simulating bone tumors, [Collins & Collins] *431
in etiology of occupational dermatoses, [Klauder] *112
in etiology of torticollis in children and young adults [Donaldson] *458
Industrial: See Industrial Accidents
Intracranial, angiography to evaluate, [Lofstrom] 918—ab
liver abscess from, India, 992
of birth, Brazil, 992
of cold injury, France, 1349
radial head dislocation in children from, [Stelling & Cote] *732
shock from, [Laborit] 808—ab
tetraplegia from, exoskeletal splithook prostheses in, [Nyquist] *761
TRAVEL
Asiatic, vaccine doses for children, vaccine combinations for adults, 817
European museums, [Stenn] 1090—C
what happens to investments while visiting Europe? (Business Practice) [Mitchell] *78
TREMOR
improves after ethoproparine hydrochloride for paralysis agitans, [Doshay & others] *248
in magnesium deficiency, (Council report) [Flink] *1406
quantitative measurement in paralysis agitans, [Azzate & others] *352
TREPHINATION: See Brain, surgery
TREPONEMA
pallidum immobilization test for syphilis, (Switzerland) 994; [Ledbetter] *1392; (on spinal fluid) [Miller & others] *1394
TRIAC
thyromimetic drug, United Kingdom, 1532
TRIBROMOTHYRONINE
thyroxine-like activity in experimental goiter, United Kingdom, 996
TRICHINOSIS
safe test inswection method for? 341
TRICHLOROETHYLENE
hazards of exposure, cough and bronchospasm from? 248
TRICHOMONAS
vaginalis, 2-acetylamino-5-nitrothiazole for, [Plenti] 745—ab
TRICYCLAMOL METHYLSULFATE
N.N.R., 467
TRIDIHEXETHYL IODIDE
N.N.R., 389
TRIETHYLENE MELAMINE (TEM)
toxicity; hemopoietic depression, (reply) [France] 415—C
treatment status in leukemias, (Council report) *1228
TRIIODOTHYRONINE
derivative, Triac, United Kingdom, 1532
metabolic and therapeutic effects, [Frawley & others] *646
TRIMETHYLENE DIUREXAINE
local anesthetic, India, 1164
TRINITROPHENYLMETHYLNITRAMINE: See Tetryl
TRIONINE: See Triiodothyronine
TRITHEON: See 2-Acetylamino-5-nitrothiazole
TRYPANOSOMIASIS
Peru, 315
TRYPSIN
intramuscular in acute poliomyelitis, (scientific exhibit) [Boinay] [1] Jan. 28
TUBERCLE BACILLUS
blood and egg media to isolate, [Dunlop] 645—ab
Koch's, streptomycin and isoniazid resistant, [Besta] 417—ab
laryngeal swabs to detect in absence of sputum, [Campbell] 708—ab
tuberculin reaction indicate presence of? 920
TUBERCULIN
reaction indicate presence of live bacilli? Reactor conversion possible? 920
treatment plus streptomycin before surgery in pulmonary tuberculosis, United Kingdom, 1255
TUBERCULOSIS
changing character of, United Kingdom, 1351
death rate, Peru, 1253
energy expended during rest, United Kingdom, 1532
experimental, isoniazid prevents, [Ferebee] 906—ab
fatal from BCG vaccination, [Falkmer] 145—ab
free treatment for indigent, India, 993
immunization, BCG, for initial attacks in children, [Gernet-Rieux] 718—ab
immunization, BCG, mass: discontinue in Scandinavia? [Wallgren] 145—ab
immunization, BCG, (Morocco) [Gaud] 357—ab; (Norway) 500; (Brazil) 586; (France) [Mande] 1374—ab

TUBERCULOSIS—Continued
in Belgium, [Jeurissen] 337—ab
in children, (France) 992; (Peru) 1253; (primary) [Raynaud] 1435—ab
in Europe, 995
in Finnish Armed Forces, 892
in infants, is Vollmer test indicative of? 726
in nurses, [Myers] 908—ab; (preventing in students) 1183
in young adults, Switzerland, 797
luposa, calciferol alone for, [Marcussen] 322—ab
morbidity among Yemenite immigrants, Israel, 581
National Ass'n. Against, extending activities, Sweden, 698
Pennsylvania Tuberculosis and Health Society research grants, 490
protecting infants against, [Gaisford] 81—ab
sanatorium establishment, infection incidence among personnel; perform surgery in general hospital? 423
severe, cocarboxylase for, [Petruccioli] 1262—ab
surgery room also safe for general surgery? 610
treatment, cycloserine, [Ravina] 604—ab
treatment, drug selection, [Robitzek] 1534—ab
treatment, hormones, France, 1162
treatment, nicotinaldehyde semicarbazone and isoniazid, Ireland, 1253
treatment, request drugs for Korean hospital, [Codington] 232—C
treatment, salizid, Ireland, 797
treatment: streptomycin, isoniazid, PAS and early surgery, [Allen] 508—ab
tuberculous hypocorticalism, [Besta] 907—ab
U. of Pennsylvania to study in American Indians, 576
Utah Trudeau Society organized, 688
TUBERCULOSIS OF LUNG
after gastrectomy, India, 695
bronchography dangers in, [Perry] 246—ab
chronic, bronchography in, France, 1089
complications: bronchostenosis incidence, Finland, 580
complications: emphysema, surgery for, [Newman] 1387—ab
diagnosis, chest x-rays value in, (reply to Dr. Garland) [Zahn & others] 317—C
in armed forces, Norway, 583
irregular hospital discharges of patients, [Sands] 508—ab
lesions, modification, Brazil, 1426
miliary, with tuberculous meningitis, prognosis, [De Angelis] 716—ab
minimal, in Royal Air Force, 898
missing patient, Edward Martin Lavor, (photo) [Hirsch] 997—C
relapse after exeresis for, Switzerland, 995
relapses, France, 1428
surgical treatment, [Oliver] 1433—ab
surgical treatment, exeresis, [Nuboer] 141—ab
surgical treatment, extraperiosteal apicolysis with plombage, United Kingdom, 1532
surgical treatment, lung decortication, [Savage] 912—ab
surgical treatment, pneumoperitoneum of value? 312
surgical treatment, pneumoperitoneum; spontaneous pneumothorax after, Brazil, 312
surgical treatment, resection in cavitary type, [Holland] 912—ab
surgical treatment, tuberculin and streptomycin before, United Kingdom, 1255
treatment, [Amberson] 592—ab
treatment, chemotherapy prolonged, England, [Hoyle] 707—ab; 1166
treatment, cyanacetic acid hydrazide, [Serembe] 147—ab
treatment, intracavitary isoniazid, [Racine] 137—ab
treatment, postural recumbency in, [Breathnach] 707—ab
treatment, streptomycin and isoniazid; bacilli resistance after, [Besta] 417—ab
treatment, streptomycin and PAS, [Tucker] 322—ab; (plus isoniazid) [Tucker] 323—ab; (allergy fatal) [Hansen] 509—ab
treatment, streptomycin, liver and vitamins B, [Pozzi] 1262—ab
x-ray dangers after artificial pneumothorax or pneumoperitoneum, United Kingdom, 585
TUMORS
cell types and histology in lung cancer, [Olcott] 333—ab
diagnosis of spinal cord compression by, [Rowbotham] 601—ab
erythropoietic morphology in presence of, [Korinth] 245—ab
Hürthle cell, India, 696
in aberrant thyroid, [Sabbatini] 903—ab
malignant, of thyroid, conservative surgery for, [Crile] 140—ab
melanin forming, tyrosine tagged with C^{14} to study, Switzerland, 414
TUMORS—Continued
metastases could cause indurated corpora cavernosa, (reply) [Paquin & Roland] 610
nonfunctioning, of adrenals, Peru, 1164
of bone, benign conditions simulating, [Collins & Collins] *431
of carotid body, recurrent, [Arean] 138—ab
of lungs, diagnosis, Brazil, 580
of rib, primary, [Barrett] 713—ab
of soft-tissue, with osteomatosis and polyposis of colon: familial syndrome, [Weiner] 142—ab
of thoracic and cervical spinal cord causing leg pain, [Scott] *328
of thymus with blood dyscrasias, (Diagnostic Problems) [Ramos] *1317; (comment) [Loeb] *1319
palpable contractile pyloric, in the newborn, [Craig] 916—ab
palpable prostatic, [Jewett] *838
parietal, without signs of, Peru, 895
parotid gland fatty infiltration simulating, [Gilman & others] *48
photographing in uterine canal, [Norment & Sikes] *1014
Polypous: See Polyps
retroperitoneal, Italy, 696
TURTON, R. H., new Minister of Health, United Kingdom, 585
TWINS
identical, successful kidney homotransplantation between, [Merrill & others] *277
two primary breast cancers, chance of occurring in twin, 1374
TWO-STEP Test (Master): See Heart function
TYLENOL: See N-Acetyl-p-aminophenol
TYMPANIC Membrane: See Ear
TYPHOID
Bacillus: See Eberthella: Salmonella
carrier, treatment after acute attack, 518
carriers: diagnosis, treatment, urine should be examined, (reply) [Enright] 342
treatment, intramuscular chloramphenicol, N.N.R., 671
vaccination for children for Asiatic travel, 817
TYPHUS
epidemic, first case in South America, Brazil, 225
vaccination for children for Asiatic travel, 817
TYROSINE
C^{14}-tagged, to study melanomas, Switzerland, 414
TYVID: See Isoniazid

U

ULCERS
marginal esophagogastric ulceration, [Wolf] 706—ab
tuberculous, of bladder, monoxychlorosene for, [Lattimer & others] *544
ULNA
fatigue fractures, [Evans] 913—ab
Monteggia fracture, [Mobley] 142—ab
ULTRASONICS
biophysical basis of use, [Schwan] *191
ULTRAVIOLET RAYS
aid for blind physiotherapists in administering, United Kingdom, 898
filter through glass and plastics? 1438
irradiated antirabic vaccine, France, 133
UMBILICAL CORD
blood coccidioidomycosis antibody after maternal infection, [Smith & others] *546
rupture, Austria, 794
UMBILICUS
hernia, huge omphalocele ruptured in utero, [Meltzer] *656
UNDULANT FEVER: See Brucellosis
UNIONS: See Industrial Trade Unions
UNITED STATES
Air Force: See Aviation, U. S. Air Force
Congress: See Laws and Legislation, federal
government aid for medical research, [Shannon] *1029; (comments on the President's recommendations) [Davidsohn] 1091—C
government contributions, planning and medical stockpile in civil defense, [Whitney] *1195
representative to WHO: Dr. Reuling, 1322
Senate, Dr. R. L. White announced candidacy, Idaho, 488
UNIVERSITY
faculty salaries, United Kingdom, 1429
of Arizona, USPHS grant for Indian health survey, 300
of Buenos Aires, Prof. Houssay reinstated, 687
of Buffalo, (to teach history of medicine) 63; (study of changes in physicians' careers) [Terris & Monk] *653; (Medical Alumni Spring Clinical Day) 1079
of Illinois, (student medical examination system altered) 1241; (crippled children clinics) 1418
of Maryland sesquicentennial and centennial, 784
of Pittsburgh Schools of Health Professions, building proposed, (photo) 217
UNIVERSITY—Continued
of Rochester, (A. D. Kaiser memorial professorship) 303; (clinic for mentally retarded children) 570
of Southern California courses in radioactive isotopes, 300
of Tennessee medical units expanded, 125
of Utah postgraduate medical education program, [Warner & Bowers] *1306
of Vienna, (summer pediatric psychiatry course) 305; (photo of painting of "Professoren Collegium") 405
of Washington, clinic for mentally retarded children, 571
of Wisconsin, pediatric professorship, 1338
Scripps Foundation study of children of college graduates, 65
State U. of Iowa establish eye bank, 361
State U. of New York College of Medicine, Levy Memorial student loan fund, 302
U.C.L.A. civil defense program, 401
UREA
effect on cerebrospinal fluid pressure, [Javid & Settlage] *943
formaldehyde resin in facial tissues, allergy to, [Peck & Palitz] *1226
UREMIA
contraindication to malaria for nephrotic syndrome, [Gilbertsen & Bashour] *25
low sodium diet in control, [Falls] *251; (reply) [Allen] 997—C
URETERS
surgically injured, repair of, [McDonell] 142—ab
URETHAN
treatment of multiple myeloma, 1374
treatment status in leukemias, (Council report) *1228
URETHRA
diverticulum in the female, [Kight] 327—ab
URETHRITIS
prostatic fluid, white cells in, compared to prostatitis, [O'Shaughnessy & others] *540; (replies) [Moore; Rosenbloom] 1257—C
URIC ACID
hyperuricemia, heredity in, [Hauge] 238—ab
URINARY SYSTEM
calculi, colloid bodies in, [Hillenbrand] 330—ab
calculi, recurrent urolithiasis: salicylates for, [Prien & Walker] *355; [Baker & Connelly] *1306
infection, nitrofurantoin for, [Stewart & Rowe] *1221
infection, Uresulfin for, [Toland & Schwartz] *542
infections, 210—E; (reply) [Sherrod] 1091—C
URINE
aldosteronuria and hyperkalemia, Switzerland, 1165
Amino Acids: See Aminoaciduria
calcium, edathamil alters test for, [Carr & Frank] 1258—C
colloid bodies in, [Hillenbrand] 330—ab
examine to diagnose typhoid carriers, (reply) [Enright] 342
glucuronides to evaluate salicylamide and acetylsalicylic acid for urolithiasis, [Prien & Walker] *355
gonadotropins to control testosterone for male infertility, [Charny] *98
incontinence, psychological harm from alarm type treatment? 1374
lead, edathamil calcium-disodium effect on, in battery workers, [Manville] 86—ab
pepsinogen, should be routine test, Peru, 315
Porphyrin in: See Porphyria
Protein in: See Albuminuria
radioactive phosphorus and calcium to study excretion, Austria, 1086
sodium, test for adrenocortical insufficiency, [Perlmutter] *117
steroid (copper-reducing) in psychiatric disorders, [Merivale] 599—ab
study in children drinking fluoridated and nonfluoridated water, [Schlesinger & others] *21
suppression from tubular necrosis after abortion, [Bull] 1434—ab
suppression in chronic nephritis, [Vallery-Radot] 811—ab
UROCATHEPSIN
determination, significance of, Swiss gastroenterologists discuss, 316
UROKON: See Acetrizoate, Sodium
UROLITHIASIS: See Urinary System calculi
UROLOGY
evolving trends in, [Higgins] *10
Italian society discusses prostatectomy, 894
metabolic unit in genitourinary hospital, United Kingdom, 1256

UROSULFIN
treatment of urinary infections, [Toland & Schwartz] *542
URTICARIA
treatment, prednisone, [Feinberg & Feinberg] *264
UTERUS
blood flow estimation in pregnancy at term, [Metcalfe] 81—ab
cervical biopsy techniques, Austria, 1347
cervical pathology and sterility, [Buxton] 144—ab
cervical secretions to study endocrine function, stains for, 726
dilatation and curettage, thiopental-nitrous oxide for? 518
double, with rudimentary vagina, Brazil, 312
Excision: See also Uterus Cancer
excision, total vs. subtotal in women under 35; leave ovary in? 249
pregnant, rupture, [Bak] 144—ab
rupture risk after 4 or more cesarean sections, [McNally & Fitzpatrick] *1005
tumors, photographing with water hysteroscope and endoscopic camera, [Norment & Sikes] *1014
UTERUS CANCER
diagnosis, cervical biopsy using cold-knife conization, [Sect & Rearan] *545
diagnosis, Erie County Medical Society organizes cytologic laboratory, N. Y., 463
of cervix and gestation, [Runge] 82—ab
of cervix in Jews, Israel, 994
of cervix, reappearance 30 years after radium treatment, [Hawkins] 999—ab
of endometrium, surgery for, [Smith] *1468
UVEITIS
recurrent, retinal detachment from? 1374

V

VACCINE
antirabic ultraviolet irradiated, France, 133
BCG: See Tuberculosis, immunization
bacterial, for rheumatoid arthritis? 1099
Influenza: See Influenza vaccine
Salk: See Poliomyelitis vaccine
VAGINA
bean in peritoneal cavity after inserted into, United Kingdom, 1353
cancer, India, 1163
rudimentary, with double uterus, Brazil, 312
secretions to study endocrine function, stains for, 726
smear in determining date of delivery, [Lemberg-Siegfried] 82—ab
VAGOTOMY: See Nerves, vagotomy
VALMID: See Ethinamate
VALSALVA MANEUVER
test for lung congestion using, [Knowles & others] *44
VALVOTOMY: See Mitral Valve
VANDERBILT UNIVERSITY SCHOOL OF MEDICINE
annual scholarship from insurance co., 124
VARICOSE VEINS
hormonal cause in pregnancy, [Fried] 1535—ab
VASOMOTOR SYSTEM
menopausal instability, pituitary factors effect on, [Hellbaum] 999—ab
VASOPRESSIN
hydration and, for congestive heart failure, water excretion after, [Hanenson] 1432—ab
role in water metabolism, Israel, 581
VEGETABLES
nutritional value of quinua, Peru, 698
will hydrochloric acid remove insecticides? 689
VEINS
accidental injection of air into, aspirating from heart, 817
auxiliary occlusion, anticoagulants for, [Marks] 862—ab
calculi, phleboliths in hemangioma of colon, [Bailey & others] *658
congestion in legs, hyaluronidase in, [O'Brien] 712—ab
grafts in legs, [Dye] 867—ab
great cardiac occlusion, and coronary artery ligation, [Siderys] 712—ab
hepatic and renal; inferior vena cava occlusion between, (replies) [Jacobsen] 1100; [Caswell] 1374
Inflammation: See Phlebitis
roentgen study, intraosseal phlebography, Austria, 132
VENA CAVA
inferior ligation after nephrectomy, [Bolman] 1368—ab
inferior ligation for heart decompensation, Austria, 1347
inferior occlusion between renal and hepatic veins, (replies) [Jacobsen] 1100; [Caswell] 1374
VENEREAL DISEASE
international symposium, Washington, D. C., 1956, 129
"VENTRAL HANGING-THROUGH" for lumbar herniated disks, [Weiss] 511—ab
VENTRICULAR FIBRILLATION
treatment, chemicals, [Burmeister] 709—ab
VERATRUM
treatment of hypertension, [Coan] 593—ab
treatment of hypertension, variables in evaluation, [Shapiro] *20
treatment plus Rauwolfia in toxemia and hypertension in pregnancy [Voskian] 999—ab
Viride: See Alkavervir
VERILOID: See Alkavervir
VERSENATE: See Edathamil
VERTIGO
aural, Rauwolfia effects on, [Lewis & others] *622
cervical, [Ryan] 914—ab
VETERANS
mustard gas poisoning in, bronchitis relation to cancer after, England, 314
V. A. long-term mental care program, 309
V. A. rating of compensation cases, 1342
VIADRIL: See 21-Hydroxypregnanedione Sodium Succinate
VIRESATE
tests and standards, 1655
VIRBARBITAL, N. F.
N.N.R., 871
VIRCHOW-TROISIER NODE
tumor emboli in pathogenesis, [Zeidman] 721—ab
VIRUS
Hepatitis: See Hepatitis, Infectious
infection recurrent in intestines, treatment, 1438
of Behcet's disease, [Sezer] 1370—ab
research in viral disease, Israel, 993
VISCERA
hemorrhages in hyperfolliculinism, [Klotz] 144—ab
signs in generalized scleroderma, [Piper] 244—ab
vasodilation in neurovegetative infections syndrome, Switzerland, 1253
VISCUS: See Organs
VISION
A.M.A. reprint: "Estimation of Loss of Visual Efficiency," 295
defects in exophthalmos with thyroid disease, [Hedges] 604—ab
subnormal, magnification for, [Gordon] 331—ab
VITAL STATISTICS
annual report of Ministry of Health, United Kingdom, 501
illnesses treated by physicians, (Bureau article) [Dickinson] *213
in England and Wales, 1351; 1352
in Scotland, 1089
in Spain, 896
life expectancy rates, Ill., 122
morbidity among Yemenite immigrants, Israel, 581
morbidity in Ontario hospitals, Canada, 1088
mortality in cancer, Switzerland, 316
mortality in Hodgkin's disease compared to leukemia, [Shimkin] 721—ab
mortality in hypertensive cardiovascular disease, [Smithwick & others] *1023
mortality, maternal; Franklin County (Ohio) study, (Council article) *296
mortality, prognostic value of life insurance study, [Bolt & Lew] *736
operative risk in 1955, [Moyer & Key] *853
VITAMINS
adrenals relation to, Italy, 894
requested for the Navajos, [Cullen] 415—C
treatment in nausea and vomiting in pregnancy, (Council report) *208
VITAMINS A
deficiency in pathogenesis of Norwegian scabies, France, 580
VITAMINS B COMPLEX
B_1: See Thiamine
B_6: See Pyridoxine
B_{12}: See Cyanocobalamin
treatment plus streptomycin and liver in pulmonary tuberculosis, [Pozzi] 1262—ab
VITAMINS C: See Ascorbic Acid
VITAMINS D
D_2: See Calciferol
state in children who take no cod-liver oil, England, 72
VITAMINS E
importance, international convention on, Italy, 133
treatment of menstrual dermatitis, Switzerland, 995
VITAMINS K
vitamin C with, to prevent bleeding after adenotonsillectomy, [Harkins] 1536—ab
VITILIGO
depigmentation of face possible from, 340
intestinal infections and, India, 797
VODKA
whiskey gives less relief to heart patient, why? 610
VOMITING
in pregnancy, status of therapy in, (Council report) *208
periodic headache in girl 8 relieved by, 1185
postanesthetic; dimenhydrinate, chlorpromazine, and pentobarbital sodium for, [Knapp & Beecher] *376
postoperative, dimenhydrinate to control; interpreting statistics, (reply) [Zeisler] 318—C

W

WALKING
pigeon-toed, caused by flatfoot; Denis Brown splints for, (reply) [Starr] 90
prematurity and walking, United Kingdom, 1256
WASHINGTON
Office: See American Medical Association
WASHINGTON (state)
Sickness Survey, illnesses treated by physicians, (Bureau article) [Dickinson] *213
WATER
excretion after intravenous hydration in congestive heart failure, [Hanenson] 1432—ab
fluoridated and nonfluoridated, urine study in children, [Schlesinger & others] *21
fluoridated (high content), x-ray study after using 10 years, [Leone] 148—ab
fluoridation at Army Posts, 1527
fluoridation studies, United Kingdom, 501
metabolism, effect of blood loss and transfusion, [Fleat] 419—ab
metabolism, effect of Pitressin and liver, Israel, 581
supplies, more needed in cities, 1423
waterpipe smoking and lung cancer, 248
WEBER-CHRISTIAN DISEASE: See Panniculitis
WEIGHT: See Body weight; Obesity
WELDING
protecting the eyes of worker and employees nearby, 424
WHIPPLE'S DISEASE
extraintestinal x-ray signs, [Kyler & Doub] *534
WHISKEY
in etiology of larynx cancer, [Wynder & others] *1384
vodka gives more relief to heart patient, why? 610
WHITE, RAYMOND L., announced candidacy for U. S. Senate, Idaho, 488
WHITE HOUSE
conference on education, health implications, 120—E
WHOOPING COUGH
antigen (non-cellular), epidemiology, [Felton] 146—ab
diphtheria and tetanus toxoids with, potency and dosage control, [Greenberg & Benoit] *198
fever reaction after triple vaccine, 1004
vaccination in the newborn, England, 413
WILSON'S Disease: See Lenticular Nucleus
WOMAN'S AUXILIARY
Chicago meeting program, 1485
Today's Health available to nurses at discount through, 295
WOMEN
value of yearly physical survey, [Rutherford & Ranke] *1289
WOOD ALCOHOL: See Methyl Alcohol
WOOD'S GLASS
to detect tinea capitis in adolescence, 424
WORDS AND PHRASES: See also Terminology; Medicolegal Abstracts at end of letter M for retraining in aphasia, 816
WORK: **WORKMEN**: See also Industrial Health
effect of work on blood pressure, France, 695
WORKMEN'S COMPENSATION: See also Industrial Accidents; Medicolegal Abstracts at end of letter M
A.M.A. publications, 879
WORLD HEALTH ORGANIZATION
cosponsors International Symposium on Venereal Diseases, 129
in protection from atomic radiation, 1252
malaria control program, 1254
members of board appointed by President Eisenhower, 691
report on cardiovascular disease, 316
report on poliomyelitis, 315
sponsor antirabies treatment, 1254
study of nursing education, 797
WORLD MEDICAL ASSOCIATION
constitutional amendment, A.M.A. proposes, 1323
WORLD WAR II (1939-1945)
"Hiroshima Diary," by M. Hachiya, comments on book review, [Hall] 999—C
WORMS, anthelmintics evaluated, France, 695

WOUNDS
gunshot, in a hemophiliac, animal antihemophilic globulin and surgery for, [Fraenkel] 419—ab
operative, cancer-cell seeding, [Smith] 711—ab
thoracic and abdominal surgical, healing with or without dressings, [Palumbo & others] °553
WRIST
complication in espresso coffee dispenser operators, United Kingdom, 1532

X

XANTHINES
treatment of coronary disease, N.N.R., 51
XANTHOMATOSIS
familial, with essential hypercholesteremia, Denmark, 412; [Piper] 594—ab

Y

YELLOW FEVER
control in Latin America, WHO and Pan American Sanitary Bureau studies, 1421

Z

ZOXAZOLAMINE
treatment, [Amols] °742
treatment of cerebral palsied children, [Abrahamsen & Baird] °749
treatment of rheumatic diseases, [Smith & others] °745
treatment of spasticity, [Rodriguez-Gomez & others] °752

AUTHOR INDEX

The asterisk (*) indicates an original article in The Journal.
For subject index see page 3.

A

Aarseth, A., 1366
Aarsvold, C. M., 1265
Abbott, K. H., 914
Abouiker, P., 1535
Abrahamsen, E. H., *749
Abramson, D. J., *874
Adlercreutz, E., 337
Agate, F. J., Jr., *348, 352
Agranat, A. L., 332
Agress, C., *16
Ahnsjö, S., 808
Albert, M. A., 241
Albright, H. L., 326
Allen, A. R., 508
Allen, F. M., 135, 997
Amberson, J. B., 592
Amols, W., *742
Anders, W., 325
Andersen, E., 712
Andersen, H. A., *1274
Anderson, C. E., *1315
De Angelis, P., 716
Appel, K. E., 392
Arean, V. M., 138
Arnold, H. L., Jr., 1001
Asboe-Hansen, G., 603
Ascher, X. W., 415
Asher, L. M., *1281
Asherman, J. G., 513
Ashley, R. K., *256
Aub, J. C., 333
Augusto, A., 333
Ausherman, H. M., *175

B

Baçaj, T., 810
Bacon, H. E., *628
Badenoch, J., 321
Badger, T. L., 148
Baer, R. L., *184
Bailey, A. A., *455
Bailey, J. J., *658
Baird, H. W., III, *749
Bak, T. F., 144
Baker, R., *1106
Balassi, G. P., 82
Banks, A. L., *1289
Barandun, S., 1365
Barborka, C. J., *850
Baroni, V., 1534
Barrett, M. E., 1265
Barrett, N. R., 713
Barrick, C. W., *658
Bartemeier, L. H., 392
Bashour, F., *25
Basset-Lacronique, F., 721
Bastos, J., 912
Battezzati, M., 713
Bauer, G. E., 418
Baum, W. S., *923
Baxter, H., 515
Bay, E. B., *775
Bearse, C., 562
Becu, L. M., 329
Beebe, R. T., *646
Beecher, H. K., *376, *1439
Behrendt, H., 79
Bellet, S., 237, *1293
Bender, I. B., 806
Bender, L. F., *611
Benhamou, J. P., 137
Benoit, R., *108
Berens, C., *207, V. 159; *1532; V. 160; (correction) 492
Bereston, E. S., *537
Berger, E., 1368
Bergy, G. G., 239
Berkowitz, D., *1398
Berman, B. A., *766
Berman, C., 804
Best, W. R., 586
Besta, B., 417, 907
Betke, K., 1369
Beutel, A., 918
Bick, E. M., *828
Billings, W. C., *448
Bisgard, J. D., *363
Blank, I. H., *1225
Blanshard, G., 246
Blanton, S., 1355, 1472
Bliss, E. L., 81
Bloch-Michel, H., 595
Blomfield, G. W., 515
Boccardelli, V., 1261
Boines, G. J., [1] Jan. 28
Boivan, P., 596
Boland, E. W., *613
Boles, R. S., *923
Bolman, R. M., 1368
Bologna, N. A., 717
Bolt, W., *736
Bornstein, S., 600
Bost, F. C., *256
Boudin, G., 1262
Bowers, J. Z., *1306
Boyan, C. P., *1271
Boyd, D. P., 320
Bradbury, J. T., *102
Bradford, J. K., *1129
Braitman, M., 421
Brams, W. A., *437
Brancadoro, G., 334
Brazil, P., 1535
Breathnach, C. S., 707
Brehme, T., 80
Breidahl, H. D., *198
Breslow, L., 1096
Brick, I. B., 1168
Bridenbaugh, L. D., Jr., *158
Briggs, B. D., *1439
Brill, A., 1355
Brindley, P., 1179
Brinkhous, K. M., 908
Brodie, J., 904
Brodthagen, H., 1001
Brody, J. I., *1293
Bromley, L. L., 140
Brooks, T. J., Jr., *162
Bross, I. J., *1384
Broustet, P., 147
Brown, C. H., *360
Brown, G. C., 600
Brown, J. B., 598
Brownrigg, G. M., 328
Brusca, P., 243
Bucy, P. C., 1232
Bugden, W. F., 806
Bull, G. M., 1434
Bunge, R. G., *102
Burchell, H. B., *950
Burgert, W., 136
Burmeister, H., 709
Burton, A. C., 722
Bush, J. A., 594, 904
Bush, R. D., *1023
Busse, E. W., 242
Bustamante, W., 718
Butler, D. B., *1211
Buxton, C. L., 144
Byers, J. A., *49

C

Cahué A., *437
Callahan, J. A., 1173
Campbell, A. H., 708
Campbell, J. S., 999
Campi, L., 1368
Campos, O. P., 596
Capuani, G. F., 85
Carbonell Juanico, M., 602
Cardozo, P. L., 321
Carr, M. H., 1258
Carryer, H. M., 1260
Carter, J. B., 504
Carver, G. M., Jr., *1447
Casey, W. C., 330
Catalano, D., 1533
Catanzaro, F. J., *114
Catanzaro, F. P., 241
Catz, B., *1046
Caveny, E. L., 509
Cello, A., 241
Chadwick, D. L., *954
Chalmers, T. M., 1432
Chamovitz, R., *114
Chapman, J. S., 415
Charny, C. W., *98
Chase, H. C., *21
Chester, S. T., 241
Cholst, M. R., *661
Christensen, A. W., *1209
Christensen, R. C., 515
Clagett, O. T., *1274
Clark, E. C., *455
Clifton, E. E., *840
Cloward, R. B., 511
Coan, J. P., 593
Cocchi, R., 1000
Codington, H. A., Jr., 232
Cohart, E. M., 722
Cohen, A., 709, 1355
Cohen, M. M., *537
Cohen, S., *1187
Cole, A. C. E., 321
Cole, F., 135
Collins, L. C., *431
Collins, V. P., *431
Colodzin, M., *1
Colville, J. M., *931
Comens, P., *1134
Comroe, J. H., Jr., *1323
Conn, J. W., 904
Connar, R. G., 324
Connelly, J. P., **1106
Constable, K., *348
Conway, H., 240
Cook, J. R., 507
Cooley, D. A., 323
Cooley, J. C., 909
Cooper, I. S., *1444
Cornfield, E., *1121
Cornley, D. A., *1219
Cossutta, A., 82
Cote, R. H., *732
Cox, F., Jr., *931
Craig, W. S., 916
Crawford, H., *940
Crawley, C. J., 705
Creevy, C. D., 916
Crile, G., Jr., 140, 1263
Crisalli, M., 1177
Croizat, P., 604
Crosby, W. H., 1168
Cross, F. S., 337
Crossman, L. W., 1002
Culbertson, W., *1187
Cullen, B. A., 415
Cullen, C. F., *179
Cuningham, J. A. K., 1175
Cuningham, K., 1174
Cunningham, C. B., 328
Cunningham, J. A., 813
Curtis, F. K., *352
Cutler, R., *282

D

Dalton, J. C., 1366
D'Angio, G. J., *4
Dang Van Ho, 146
Dantes, D. A., *1125
David, D., 719
Davidsohn, I., 1092, 1533
Davidson, D. T., Jr., *268, *766
Davila, J. C., 140
Davis, C., Jr., *1047
Davis, E., 709
Davis, E. W., *555
Davis, F. W., Jr., 1094
Davis, L. A., *373
Davis, W. B., 76
Davison, F. W., *105
Day, E., *1384
Décourt, J., 1432
De Muth, G. R., 83
Denko, C. W., 708
Dennis, C., 911
de Peyster, F. A., *1375
Derlacki, E. L., 1436
Derra, E., 909
de Takats, G., 80
Deterling, R. A., Jr., 807
de Vries, S. I., 337
Dickinson, F. G., *213, 473
Dillon, M. L., Jr., *1447
Dillon, R. F., *1047
Dimond, E. G., 83
di Sant'Agnese, P. A., *846
Dittrich, J. K., 906
Diveley, R. L., *729, *856
Dodd, G. D., 1179
Doll, R., 904, 1365
Donald, D. E., *950
Donaldson, J. S., *458
Dordick, J. R., *285
Doshay, L. J., *348, *352
Dotto, A. C., *1271
Doub, H. P., *534
Doubilet, H., *521
Dougherty, J., 597
Doull, J. A., 907
Dragstedt, C. A., 1320
Drell, W., *16
Dressler, W., *1379
Drew, A. L., *752
Dubost, C., 321
Duchesne, B., *1403
Duffy, B. J., Jr., *858
Dujovich, A., 1179
Duncan, L. J. P., 1366
Dunlop, G. A., 605
Durst, J. B., *165
DuShane, J. W., *871, *950
Dye, W. S., 807

E

Eanet, M. P., 508
Eaton, L. M., 141
Ebeling, W. C., 1175
Edwards, F. R., 595
Effler, D. B., 805
Egbert, E., 592
Egdahl, R. H., 722
Ehrenhaft, J. L., 326
Eisert, O., 1266
Eliasoph, J., *41
Elkins, M., 513
Ellis, D. S., *1017
Ellis, F. H., Jr., 595
Engelsher, D. L., 76
Epstein, J., 503
Epstein, S., 1355
Espino-Vela, J., 1094
Estborn, B., 998
Etheredge, S. N., 510
Evans, D. L., 913
Eyler, W. R., *534, *1464

F

Fabry, C., 917
Falkmer, S., 145
Fallet, G. H., 720
Falls, F. H., *251
Farley, D. M., 1266
Feinberg, A. R., *264, 778
Feinberg, S. M., *264, 778
Fell, E. H., *1047
Felton, H. M., 146
Ferebee, S. H., 506
Ferey, D., 1535
Ferguson, A. B., Jr., 1000
Ferguson, C., 330
Ferguson, J. T., *259
Fernandez-Ruiz, C., 1266
Ferrario, E., 1369
Fieldman, E. J., 516
Figge, F. H. J., *1308
Finnegan, C., *1042
Finnerty, F. A., Jr., 997
Fisher, E. R., *204
Fisher, J., 334
Fitzgerald, J. D. L., 803
Fitzpatrick, V. de P., *1005
Flandreau, R. H., 1433
Flear, C. T. G., 419
Flink, E. B., *1406
Fois, A., 914
Foldes, F. F., *168
Ford, F. R., 1237
Ford, F. R., (Baltimore) 1264
Foreman, H., *1042
Forsander, O., 813
Forsbech, V., 509
Fountain, J. H., 317
Foxworthy, D. T., 905
Fraenkel, G. J., 419
Francis, R. C., 145
Franco, J., 415
Frank, H. A., 1258
Frank, L., 245
Frawley, T. F., *646
Frazell, E. L., 711
Frazier, H. M., *774
Frederikse, M. J. H., 329
Freeman, J. T., 327
French, L. A., 910
Fried, P. H., 1535
Friery, J. F., 1257
Funderburk, W. H., *259

G

Gabuzda, G. J., *969
Gairdner, D., 329
Gaisford, W., 81, 84
Galambos, J. T., 325
Galton, D. A. G., 331
Gambescia, J. M., *1398
Ganem, E. J., 816
Gardner, W. J., *272, *1224
Gareschè, E. F., 503
Garland, L. H., 586
Gasul, B. M., *1047
Gaud, J., 337
Gaul, L. E., 1001
Gause, G. F., 332
Gavosto, F., 812
Gebhart, W. F., *360
Gelhaus, V. M., *1308
Gentry, J. T., 721
Georgiade, N., *940
Gernez-Rieux, C., 718
Gerritzen, F., 1173
Gil, J. R., 240
Gilbertsen, A. S., *25
Gilchrist, R. K., *1375
Gilman, J. S., *48
Gilman, R. A., *48
Gilpin, W. A., 1261
Ginsberg, V., *1311
Gish, G., *864
Gitlin, D., 1177
Gittler, R., 1094
Giusti, M., 1000
Glenn, F., 1263
Glushien, A. S., *204
Godden, J. O., *1274
Gold, H., 1091
Gold, J. A., *1311
Golding, J. S. R., 418
Goldner, F., 591
Goluboff, B., 1432
Good, R. A., 710
Gordan, G. S., 1002
Gordon, D. M., 331
Gorham, L. W., 598
Gorlin, R., *44
Gottschalk, L., *1187
Govaerts, J., 1264
Grace, J. T., Jr., *1454
Graffagnino, P. N., *179
Grais, M. L., 603
Grande, F., 1366
Greaves, J. L., 716
Greenberg, L., *108
Griffith, H. W., *858
Grill, W., 1180
Gross, E. M., *967
Gross, R. E., *634
Grossi-Bianchi, M. L., *268
Grover, R. W., *1397
Groves, L. K., 807
Gruner, G., 243
Grunstein, I., 801
Guild, W. R., *277
Guillaudeu, R. L., 1258
Gunther, M., 1434
Guy, L. P., 1536
Guzzi, L., 719

H

Habel, K., *465
Hahn, R., 899
Haimovici, H., 807
Halbrecht, I., 715
Hall, J. R., Jr., 899
Halprin, H., 705
Hanenson, I. B., 1432
Hansen, J. E., 509
Harell, A., 997
Harken, D. E., 1095
Harkins, H. P., 1536
Harris, G. W., 337
Harris, J. R., 811
Harris, T. N., 1095, 1096
Harrison, J. Harold, 79
Harrison, John Hartwell, *277
Harrison, R. H., III, 1436
Hart, F. D., 239
Hassing, V., 509
Hatch, H. B., *1129
Hauge, M., 238
Haverback, B. J., 332
Haxthausen, H., 603
Hayes, M. A., 1368
Hayhoe, F. G. J., 238
Hebold, G., 999
Hedges, H. S., 604
Hedges, T. R., Jr., 604
Heilbrun, N., 246
Heilman, F. R., *928
Hellbaum, A. A., 999
Henderson, C., 1180
Hennessy, A. V., 320
Henriksen, E., 802
Hermann, I. F., *745
Herrlin, K.-M., 808
Herrmann, J. D., *1277
Hershey, J. E., 419
Heslop, I. H., 240
Hess, E., *293, *675, *1146, *1474
Hewat, J. K., 143
Hicks, C. E., 1262
Higgins, C. C., *10
Hildes, J. A., 1173
Hill, J. H., *1394
Hillenbrand, H. J., 330
Hinman, A., 915
Hirsch, L., 997
Hitzig, W. H., 81
Hodges, F. J., 605
Hoessly, G. F., 808
Hoffmann, F., 1535
Holland, R. H., 912
Holman, S. P., 913
Holmberg, G., 81
Hooker, J. W., *557
Horger, E., *868
Horovitz, I., *661
Horowitz, S., 1534
Horton, B. T., 468, (correction) 884
Horton, R. E., 1175
Hosmer, M. N., *285
Howard, J. M., *1202, *1211
Howden, P. F., 139

Howes, H. A., 1260
Howkins, J., 999
Howland, W. S., *1271
Hoye, S. J., 1175
Hoyle, C., 707
Hoyne, R. M., 710
Hozier, J. B., 149, *1206
Huang, K-C., *373
Hudock, J. J., 910
Hudson, D. G., 1097
Hudson, P. B., 811
Hughes-Jones, W. E. A., 327
Hurst, E. W., 516
Hutchison, J. H., 83
Hyman, A. S., 76

I

Isaacs, B., 146
Isaacson, N. H., 911
Isaacson, S., *1311
Israel, H. L., 592

J

Jackson, R. L., 976
Jacoby, J., 516
Jacquelin, A., 918
Järvinen, P. A., 120
Janbon, C. M., 605
Janssen, E., 718
January, L. E., *622
Jaso, E., 811
Javett, S. N., 810
Javid, M., *943
Jenkins, L. B., 326
Jenkinson, E. L., *658
Jensen, E. S., 913
Jervis, G. A., *954
Jesseph, J. E., 711
Jeurissen, A., 337
Jewett, H. J., *838
Jewett, T. C., Jr., *634
Jones, A. C., Jr., 514
Jones, P., *318
Jones, W. F., Jr., 85
Judmaier, F., 911
Judovich, B. D., 1258
Juers, A. L., *451
Jung, R. C., 1096

K

Kaiser, E., 141
Kaiser, R. F., *923
Karbelnig, M. J., 587
Karliner, W., 586
Kassouny, D., *1118
Kattus, A. A., Jr., *16
Katz, L. N., *437, *1137
Katz, S., *553
Kaufmann, A., 910
Kearns, T. P., 1370
Keettel, W. C., *102
Kelley, W. J., *256
Kenney, L. J., *1464
Kent, G., 147
Kern, E., 911
Key, J. A., *853
Keys, J. R., 713
Kiene, R. H., *720
Kight, J. R., 327
Kimball, E. R., *1033
Kincaid-Smith, P., 812
Kinsey, D., *1023
Kirkeby, K., 605
Kirklin, B. R., *1327
Kirklin, J. W., *871, *950
Kirman, B. H., 420
Kirschner, L., 417
Kirtley, W. R., *1285
Klauder, J. V., *112
Klayman, M. L., 706
Klein, M., 714
Klotz, H.-P., 137, 144
Knapp, M. R., *376
Knocker, P., 80
Knowles, J. H., *44
Kobayashi, O., 810
Koprowski, H., *951
Korinth, E., 245
Korp, W., 813
Kos, C. M., 1436
Kovitz, B., 143
Krainin, P., *937
Kreidberg, M. B., 602
Krembs, M. A., *165
Kron, K. M., *745
Küchmeister, H., 138
Kuzell, W. C., 417

L

Laborit, H., 808
LaDue, J. S., *1130
Landry, W. J., 606
Lang, H. T., 1176
Lapan, B., *937
Lattimer, J. K., *544
Lauer, D. J., 1096
Lawrence, R. D., 592
Lebherz, T. B., 420
Ledbetter, R. K., *1392
Leeper, R. W., 1001
Leger, L., 86
Lemberg-Siegfried, S., 82
Lemere, F., 1431
Lemley-Stone, J., *1454
Lepage, G., *1103
Leslie, A., *1125
Levack, J., 242
Levene, C. L., 721
Levin, H., 1533
Levin, J. F., *1040
Levine, M., *1187
Levy, R. W., *1277
Lew, E. A., *736
Lewin, P., 1257
Lewis, B. I., *622
Licht, S., 76
Lidström, A., 597
Lillehei, C. W., 1095
Lim, W. N., *1457
Lindsay, S., 813
Linton, R. R., *1017
Lipschitz, E., *168
Lisle, A. C., Jr., *1277
Litt, J. Z., *181
Loeb, V., Jr., *1319
Lofstrom, J. E., 918
Lombroso, C. T., *268
Looney, J. M., 907
Looney, W. B., *1
Lorber, M., 594
Loubatières, A., 1536, 1536
Loyke, H. F., 237
Lubin, R. I., *622
Luckhardt, A. B., 504
Lübbers, P., 139
Lull, G. F., 1235
Lushbaugh, C. C., *1042

M

Maas, M. J., 1090
McCall, R. E., *1403
McCarroll, J. R., 600
MacCarty, W. C., Jr., 335
McClintock, J. C., *646
McCubbin, J. W., *272
McDaniels, J. H., *1193
McDermott, W. V., Jr., 593
McDonald, J. C., 320
McDonell, T. H., 142
McDowell, J. S., 1235
McEachern, C. G., 137
McKay, J. W., 336
McKeown, T., 916
MacLean, L. D., 79
McMurrey, J. D., 1097
McNair, J. D., 331
McNally, H. B., *1005
McNeill, R. S., 906
Maguire, C., *940
Maisel, B., *868
Makous, N., 903
Malosetti, H., 238
Maltby, E. J., 803
Mande, R., 1371
Manning, W. K., 507
Manson, D. I., 802
Manville, I. A., 86
Marcussen, P. V., 322
Margolis, E. T., 801
Marie, J., 1369
Marks, J., 802
Marley, E., 809
Marshak, R. H., *41, 606
Marten, R. H., 1000
Marthy, G. L., *646
Martin, R., 603
Martin, W. J., 85, *871, *928
Mason, H. H., 718
Mathé, C. P., 917
Mathews, W. H., *1467
De Matteis, F., 507
Maver, C. F., 510
Maver, E., 231
Melamed, J. L., *463
Meltzer, A., *656
Mendelson, C. E., *437
Meneely, G. R., *1454
Meng, H., 143
Menguy, R. B., 1178
Mensor, M. C., 512
Merivale, W. H. H., 599
Merrill, J. M., *1454
Merrill, J. P., *277
Metcalfe, J., 81
Metcalf, P. B., Jr., 595
Meyer, K. F., *954
Meyer, L. M., *1312
Meyer, P. W., *729
Mikal, S., *49
Milch, H., *641
Miller, D. S., 598
Miller, J. L., *1394
Miller, J. M., 1261, 1431
Mills, E. S., *1467
Milnor, W. R., 1262
Mitchell, P. N., 78
Mobley, J. E., 142
Moe, T. I., *162
Mörch, E. T., *864
Mollaret, P., 80
Molomut, N., *967
Monaldi, V., 1367
Monat, H. A., 708
Moncke, C., 705
Monk, M., *653
Monnig, P. J., *853
Monto, R. W., 137
Moore, C. B., 1257
Moore, D. C., *158
Moore, M. T., 913
Morello, A., *1444
Morgan, M. C., *206
Morin, M., 1264
Morino, F., 710
Morris, A. J., *114
Morris, D., 602
Morson, B. C., 514, 514
Mortensen, C., *1329
Mosbech, J., 1173
Moyer, C. A., *853
Mulholland, J. H., *521
Muller, C.-A., 1365
Mullins, J. F., 244
Murakami, J., 599
Murphy, F. J., 1097
Murphy, J. T., *385
Murray, J. E., *277
Muzzolini, G., 119
Myers, J. A., 908
Myschetzky, A., 1176

N

Nabarro, J. S. N., 239
Narabayashi, H., 998
Navratil, L., 138
Neefe, J. R., *1118
Nelsen, D. J., *954
Nelson, C. T., 244
Nelson, R. S., *764
Nelson, T. L., *954
Nelson, W. O., *102
Newburger, R. A., *41
Newman, R. W., 1367
Nichols, D. R., *928
Noble, J. H., 335
Nolan, J. P., 512
Norby, W. C., *1331
Norment, W. B., *1014
Norris, R. F., *1118
Northfield, D. W. C., 869
Northrop, C., 317
Norton, T. W., *954
Nowill, W. K., *175
Nuboer, J.-F., 141
Nuñez, P. V., 1177
Nyquist, R. H., *761

O

O'Brien, P., 712
O'Brien, R. G., *819
Occhipinti, S., 805
Ochsner, A., *1129
Oglevie, R. R., *856
Olcott, C. T., 333
Oliver, R. K., 1433
Olsen, C. W., *39
Olson, S. W., *1202, *1211
Olwin, J. H., *1101
Orecchia, C., 1367
Orgain, E. S., 593
Orkin, L. R., *1465
Ormsby, H. L., 331
O'Shaughnessy, E. J., *540
Osserman, K. E., *153
Ottaviani, P., 804
Otto, J. F., Jr., 510
Overton, D. E., *21

P

Page, J. A., 239
Palazzo, W. L., 243
Palitz, L. L., *1226
Pallis, C. A., 1370
Palmer, E. D., 241
Palmer, T. H., 596
Palumbo, L. T., *553
Pang, L. Q., 719
Paquin, A. J., Jr., 330
Parker, M. L., *463
Parola, P. L., 910
Parrino, P. S., *510
Parrish, A. E., 331
Patrick, R. T., *950
Peabody, J. W., Jr., *555
Peak, W. P., *745
Pearson, O. H., 324
Peck, S. M., *1226
Pedrazzini, A., 908
Perlmutter, M., *117
Perlstein, I. B., 708
Perosa, L., 514
Perreau, P., 147
Perry, K. M. A., 246
Peters, G. A., 1178
Peters, P. M., 1178
Petrucciolli, L., 1262
Petterson, H. O., Jr., 148
Pickrell, K., *940
Pignero, A., 711
Pinckney, E. R., *1450
Piper, J., 594
Piger, W. N., 244
Pippard, J., 599 (3)
Pirk, L. A., *168
Pirkey, E. L., *373
Plenti, A. A., 715
Pochin, E. E., 1180
Poloukhine, N., *1444
Pool, T. L., *833
Pope, A. S., 1265
Poutasse, E. F., 1435
Povoa, E. B., 245
Powell, L. W., Jr., *557
Pozzi, G., 1262
Prien, E. L., *355
Priestley, J. T., *198
Prior, I. A. M., 84
Prout, G. R., *840
Pruce, A. M., 899
Pulaski, E. J., 1097
Purpura, F., 138

Q

Quaini, P., 1369
Quinn, E. L., *931

R

Racine, R., 137
Rae, J. W., Jr., *511
Raffensperger, J., 899
Rammelkamp, C. H., Jr., *114
Ramos, A. J., *1317
Ramse, O. B., 715
Rance, C. P., 716
Randall, C. L., 810
Rappaport, I., 231
Rasmussen, P., 712
Ratner, H., 232
Ravina, A., 604
Raynaud, J., 1435
Raynaud, R., 591
Reagan, J. W., *343
Reich, A., *360
Reifferscheid, M., 1433
Reinhold, J. G., *1118
Reisner, E. H., Jr., *206
Rhodes, I. E., *4
Ridolfo, A. S., *1285
Rienhoff, W. F., *1136
Rietman, H. J., *179
Rigler, L. G., 335
Ritter, J. A., *1219
Ritter, U., 142
Ritvo, M., *4
Rix, A., *1277
Robbins, R. D., *1315
Robinson, H. M., Jr., *537
Robinson, J. P., 800
Robinson, R. C. V., *557
Robitzek, E. H., 1534
Rodnan, G. P., 905
Rodriguez-Gomez, M., *752
Roe, D. S. A., 421
Rogachefsky, H., *184
Rogers, F. B., 801
Rogers, S. F., 1090
Rogers, W. S., 716
Rosenbloom, D., 1257
Rosenthal, S. A., *184
Rosove, L., *1125
Rossi, L., 514
Rovenstine, E. A., *1465
Rowbotham, G. F., 601
Rowe, H. J., *1221
Rowntree, L. G., 1258
Rubin, C. E., 706
Runge, H., 82
Rutherford, R. N., *1289
Ryan, G. M. S., 914
Rynearson, E. H., *198

S

Sabbatini, C., 903
Sacco, F., 802
Sadove, M. S., 876
Saito, M. T., *546
Salamon, S. D., 703
Salmoiraghi, G. C., *1224
Salvesen, H. A., 322
Sánchez Medal, L., 1002
Sanders, L. C., 1264
Sandock, I., *659
Sands, J. H., 508
Sanger, P. W., *1403
Savage, T., 912
Saxton, G. A., Jr., *861
Schaefer, J. H., 586
Schaper, G., 329
Schatzki, R., 1179
Scheele, L. A., *1114
Schepers, G. W. H., 231
Schlesinger, B. E., 1434
Schlesinger, E. R., *21
Schmidt, H. W., 237
Schneider, L. A., 334
Schönenberg, H., 914
Schofield, H. L., Jr., 1368
Schofield, J. R., *1202, *1211
Scholz, O., 1176
Schoolman, H. M., *461
Schroeder, F. F., 1354
Schroeder, H. A., *1134
Schuckmell, N., 602
Schumann, H., 705
Schwab, R. S., *385
Schwan, H. P., *191
Schwartz, J. W., *542
Schwartz, M., *48
Schwartz, S. O., *461
Schweiger, E., *1111
Schweizer, O., *1271
Scott, M., *528
Scott, Roger B., *313
Scott, Roland B., 601
Sealy, W. C., *1447
Seelentag, W., 918
Segagni, E., 1177
Semenson, C., *16
Serembe, M., 147
Settel, E., 808
Settlage, P., *943
Seyffert, H.-M., 998
Sezer, N., 1370
Shallow, T. A., 1263
Shane, S. J., 804
Shannon, J. A., *1029
Shapiro, A. P., *30
Shapiro, H. A., 587
Shaw, F. H., 720
Shearer, T. P., *1202
Sheldon, D. B., *1439
Shelokov, A., *465
Shephard, R. J., 1260
Sherrod, T. R., 1091
Shiels, D. O., 335
Shimkin, M. B., 721
Shindell, S., *1121
Shostok, P., 419
Siderys, H., 712
Siegel, Malcolm, *840
Siegel, Morris, 513
Sikes, C. H., *1014
Silver, H., *1187
Silverman, B. K., 1095
Simeons, A. T. W., 1365
Simons, S. A., *546
Singher, H. O., *91
Singleton, E. B., 328
Sippy, H. I., *830
Skirsan, P., 334
Slatkin, M. H., *1394
Smith, A. D., 597
Smith, C. E., *546
Smith, C. F., 606
Smith, G. A., *266
Smith, G. W., 1431
Smith, H. W., *830
Smith, J. C., *1460
Smith, R. R., 711
Smith, R. T., *745
Smithwick, R. H., *1023
Snow, P. J. D., 245
Solomon, C., 604
Spence, H. M., 917
Spirito, A. L., *514
Spurr, C. L., 591
Stafford, C. E., 1433
Starr, I., 672, 1144
Starr, K. W., 418
Starr, P., *1046
Stein, I. D., 85
Stein, J. J., *1215
Steinberg, C. L., 1071
Stelling, F. H., *732
Stenn, F., 1091
Stenstrom, J. D., 803
Stephen, C. R., *173
Sterling, A., 801
Stetson, C. A., 707
Stevenson, C. A., 148
Stewart, L., *1221
Stone, H. B., *1298
Storey, C. F., *44
Stoughton, R. R., *1011
Stryker, H. H., *388
Stuart-Harris, C. H., 321
Stuckey, D., 716
Sullivan, J. F., 601
Sussman, I., *1398
Sussman, L. N., *285
Swann, W. K., 321
Sweet, R. H., 1174
Swerdlow, M., *168
Szilagyi, D. E., 139

T

Taft, L. I., 915
Taylor, A. M., 809
Taylor, F. H., *1403
Taylor, J. R., 330
Teng, P., *153
Terman, L. A., 1176
Terris, M., *653
Terry, H. R., Jr., *950
Tether, J. E., *156
Texter, E. C., Jr., *830
Thompson, C. M., *1398
Thompson, G. J., *833
Thompson, J. H., 86
Thoms, H., *448
Thoms, J., 336
Thomson, K. F. M., 719
Timmer, H.-G., 325
Tinckler, L. F., 511
Titchener, J. L., *1187
Titrud, L. A., 242
Toland, W. J., *542
Torsegno, M., 512
Traisman, H. S., 915
Troan, J., 1258
Tronchetti, F., 86
Trounce, J. R., 507
Truant, J., *931
Tubiana, R., 597

Tucker, W. B., 322, 322, 323
Turkel, H. W., 504
Turner, H. H., 903
Tyler, E. T., *91

V

Valdes-Rodriguez, A., *752
Vallery-Radot, P., 811
Van Alta, F. A., 703
van Hazel, W., 912
van Marken Lichtenbelt, H., 333
Van Riper, H. E., 1354
Van Wyk, J. J., 1536
Varela de Seijas Aguilar, J., 501
Viersma, H. J., 905
Vinson, P. P., 704
Visscher, M. B., 135
von Haam, E., 603
Voskian, J., 999

W

Wachtel, F. W., 709
Wade, J. S. H., 713
Wahl, R., 145
Walker, B. S., *355
Walker, W., 1435
Walker, W. W., 800
Walkup, H. E., 909
Wallgren, A., 145
Wallman, I. S., 716
Wallyn, R., 896
Walser, M., *858
Walsh, T. E., 513
Walters, W., *425
Wang, W. L. L., 1371
Warner, R. S., *1386
Warren, E., 714
Warren, S. L., *1215
Warshaw, L. J., *967
Wasserman, F., *1293
Watanabe, R., *16
Weber, G., 420
Weber, G. M., *168
Wechsler, H., *544
Wedgwood, J., 321
Weed, L. A., 801
Weijers, H. A., 718
Weiner, R. S., 142
Weiner, W., 685, 1173
Weinstein, L., 144
Weiskotten, H. G., *1393
Weiss, J., 511
Weiss, M. M., 903
Wellman, M., 81
Wenner, H. A., 600
Westerberg, M. R., 998
Westerborn, A., 516
Westergaard, M., 1371
Weyl, R., 149
Wheelock, M. C., 804
White, C. S., Sr., 720
White, J. D., *540
White, P., 715
White, P. D., *1027
Whitelaw, G. P., *1023
Whitmore, W. F., Jr., *840
Whitney, J. M., *1195
Whittle, G. T., *544
Whittlesey, R. H., 717
Wickbom, I. G., 336
Wild, J. B., *822
Wildermuth, O., 146
Wilkins, H., *1277
Wilkinson, D. E., *553
Williams, R. D., *367
Wilmer, H., 1236
Wilmer, H. A., *663, *768, 1237
Wilson, M. G., *1457
Wilson, V. H., 1263
Winkelstein, A., *1111
Wise, R. E., *819
Wolf, B. S., 706
Wood, E. H., *950
Woods, J. D., 805
Wren, Wm. C., 1236
Wright, F. H., 243
Wróblewski, F., *1130
Wu, T.-C., 812
Wulff, M. H., 1176
Wyburn, G. M., 325
Wynder, E. L., *1384

Y-Z

Yagi, H., 328
Zacharias, L., 421
Zahn, D. W., 317
Zarday, I., 238
Zeavin, B. H., 1370
Zeldman, I., 721
Zeisler, E. B., 318
Zeller, W. W., *179
Zettler, F., 242
Zollinger, R. M., *367
Zondek, H., 1260
Zwerling, I., *1187

INDEX TO PAGES

OF THE JOURNAL, ACCORDING TO WEEKLY ISSUES VOLUME 160, JANUARY-APRIL, 1956

Pages	No.	Date	Pages	No.	Date	Pages	No.	Date	Pages	No.	Date
1- 90	1	January 7	345- 424	5	February 4	729- 818	9	March 3	1187-1270	14	April 7
91- 152	2	January 14	425- 530	6	February 11	819- 922	10	March 10	1271-1374	15	April 14
153- 250	3	January 21	531- 610	7	February 18	923-1004	11	March 17	1375-1438	16	April 21
251- 342	4	January 28	611- 728	8	February 25	1005-1100	12	March 24	1439-1538	17	April 28
						1101-1186	13	March 31			

CONVENTION NUMBER: April 28, 1956

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